NIMHANS

Manual of Mental health for Medical Officers

National Institute of Mental Health
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Manual of Mental Health for Medical Officers

MOHAN K. ISAAC
C. R. CHANDRASHEKAR
R. SRINIVASA MURTHY

Community Mental Health Unit
Department of Psychiatry

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NATIONAL INSTITUTE OF MENTAL HEALTH AND NEUROSCIENCES
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Dr. G. N. Narayana Reddy,
Director,
National Institute of Mental Health and Neurosciences
P.O. Box 2900
BANGALORE - 560 029. INDIA

FOREWORD

Mental illness is an age old problem of mankind. It is recorded in the oldest literatures of all cultures all over the world. Till recently, the exact causes of mental illnesses were not known and there were few effective treatment methods. Mental patients were often a source of disturbance to others. Initial efforts were to isolate them from others and keep them in closed places called 'asylums'. This did not solve the problem. When these patients had to live away from their family members and stay within the limits of the four walls of the mental hospitals, they deteriorated. Their suffering increased. This led to fear of 'Mental Hospitals'. The general public hesitated to bring their mentally ill relatives to these hospitals.

In India, most states have only one or two mental hospitals and people find it difficult to reach these centres. In the last 30 years, sufficient research has been carried out to understand the nature of mental illnesses and to evolve effective treatment methods. Currently, inexpensive and effective, treatment methods like drugs are available. However, these facilities have not reached the patients who live in the rural areas. Since majority of our population live in rural areas, large number of mental patients do not get the benefits of modern treatment.

At NIMHANS, Bangalore, during the last 10 years, efforts were directed to examine the feasibility of treating mental patients in their own houses. The results of these experiences have shown that most of these patients can be cared for in their homes, using a limited range of inexpensive drugs, family counselling and support. Trained doctors and paramedical personnel can effectively look after these patients and help them to recover early. This means that mental health care can be provided at primary health units and primary health centres by which people can easily make use of them. This involves minimum expenditure and no social stigma.

In India, a National Mental Health Programme (NMHP) has been formulated. This programme aims to integrate mental health care into the existing general health system. The NMHP was approved by the Central Council of Health and Family Welfare in 1982. For the first time in the country Ministry of Health and Family Welfare of Karnataka state in April 1982 started deputing doctors and health workers for inservice training in mental health care at NIMHANS, Bangalore on a regular basis.

In the above approach, health workers would identify people with mental illnesses in their areas, bring them to primary health centres for treatment and manage them in the community. Most of the patients need care over a long period of time. Health workers, as they visit the homes to carry out other health programmes, follow up the mentally ill persons. They can educate people to increase the awareness about mental health and gradually remove their misconceptions and unscientific practices.

This manual describes how **Medical Officers** can implement this programme. I hope that this manual serves as a guide for them in this task, and result in better care for mentally ill in our country.

Dr. G.N. Narayana Reddy
Director
NIMHANS, Bangalore

September, 1985

PREFACE

The various general population surveys of mental illnesses carried out in different parts of India during the sixties and seventies, showed that these illnesses are as common in our country as it is elsewhere and are equally common in rural and urban areas. Simple inexpensive and effective treatment methods for many of these serious and disabling disorders, are now available. In India, currently psychiatric care is provided mainly through custodial mental hospitals and general hospital psychiatric units, all of which are situated in the cities. It is estimated that these existing services presently cater to only about 10% of those requiring mental health care. There is an urgent need to develop and evaluate alternative approaches to mental health care delivery system which is feasible and relevant to the Indian situation.

The Department of Pyschiatry at the National Institute of Mental Health and Neuro Sciences — one of the oldest and largest in the country — took up the challenge of extending mental health services into the community as early as 1975. A specially designated and staffed 'Community Psychiatry Unit' was established under the leadership of Prof. R.L. Kapur in 1975. The main aim of the Unit was to extend mental health services by integrating it with the existing system of primary health care. For this, the primary health care staff had to be trained in basic mental health care. More specifically, the task of the unit was to develop, carry out and evaluate suitable short term training programmes in basic mental health care for different categories of health care personnel, so that after training, these personnel could provide mental health care in their respective areas of work.

A rural health training centre was established at Sakalawara (community mental health centre of NIMHANS) near Bangalore. A service programme was developed. Feasibility exercises were carried out in villages around Sakalawara. Based on these experiences, simple manuals of instructions and short training programmes for medical officers and multipurpose workers of PHCs were developed. Pilot training programmes were carried out and evaluated at Primary Health Centres at Malur and Anekal (Kolar and Bangalore Districts, Karnataka state). These pilot programmes helped the unit to crystallize the eudcational objectives for the mental health training of PHC personnel and meaningfully rewrite the manuals of instructions in basic mental health care. The revised manuals were used for training 19 batches of multipurpose workers and medical officers of various PHCs of Gulbarga division (Karnataka state) who were deputed to the Sakalawara training centre for a 'two-week training in mental health from April 1982 to December 1983'.

The experience of training 19 batches of **PHC** personnel and the feedback given b
these trainees have resulted in the revision of the manuals. Regular reviews of th
manuals by post-graduate trainees from various disciplines at NIMHANS posted t
the community mental health unit and the unit staff have resulted in the current forn
of the manual.

This manual for **Medical Officers** in its present form was rewritten by the author
for publication and large use. It is hoped that this manual will lead to the integratio
of mental health into the primary health care services, in various parts of the country

Dr. S.M. Channabasavanna
Head, Department of Psychiatry
NIMHANS, Bangalore.

September, 1985

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CONTENTS

I Mental Health as part of General Health

Health is wealth. All of us want to be healthy. However mere absence of illness is not health. A healthy person, has a sound body. He is happy and contented. He has the ability to face difficulties, losses and frustrations. He is capable of living in harmony with others. Not only is he happy but is able to do his best to keep others happy. He sees that others are not put into trouble because of him. He has certain moral and spiritual values. Such a person who is physically, mentally, socially and spiritually well can be considered to be healthy.

People become physically ill due to many reasons. Undernourishment, disease causing organisms invading the body, fluctuations in the environment, wear and tear of our organs, injury to our body, defective blood supply etc., can lead to illness. When we are ill, we consult the doctor and take treatment.

Like the body, the 'mind' too can become ill. The mentally ill person's sense of well being and equilibrium are disturbed. The various mental functions like thinking, emotions, memory, intelligence, decision making etc., get disturbed. Talk and behaviour become abnormal. The ability to work satisfactorily is impaired.

It is easy for anyone to imagine the various difficulties caused by damage or dysfunction to any pary of the body. For eg. all of us know what it is to have high fever, blindness or a broken leg. So we usually react and sympathise with a person who is physically ill or disabled. But most of us do not understand what it is to be mentally ill. We fail to sympathise with a mentally disabled person. We often neglect him. When a person becomes mentally ill, he is usually not taken to a hospital for proper treatment. To add to the problem, mental health care facilities are available only in big cities.

You are already aware of the goal **'Health for all by the year 2000 A.D.'** Our country has accepted this goal. **Provision and promotion of mental health care is one of the 8 components of primary health care.** "Education concerning prevailing problems and the method of identifying, preventing and controlling them: promotion of food supply and proper nutrition and adequate supply of safe water and basic sanitation-maternal and child health care including family planning; immunisation against major infectious diseases; prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries; **Promotion of mental Health** (emphasis added) and provision of essential drugs".

Therefore the medical officers, multipurpose workers and other health staff of primary health centres have the responsibility of delivering basic mental health care to the community along with general health care. Integrating mental health into the existing health care system is accepted for extending mental health care to the needy in the community.

MENTALLY ILL AND MENTAL HEALTH FACILITIES IN OUR COUNTRY

House to house surveys to estimate the number of mentally ill in a given community, have been conducted in our country as elsewhere in the world. According to World Health Organisation figures, in any country including ours, **one per cent** of the population suffers from severely incapacitating mental disorders and **ten per cent** from mild mental disorders. If we project these figures in our country, there would be 6 to 7 millions of severaly mentally ill and ten times that number of mildly ill persons. You know that majority of our people live in rural areas. Most of our mentally ill persons too are in rural areas.

It is also noted that nearly **15 to 20%** of people who seek medical help in primary health centres, general hospitals or private clinics, have mild mental disorders. But most of them are not aware of it. They think and believe that they have some physical illnesses. They take various drugs and treatment methods to get relief, often in vain.

While there are millions of people suffering from various types of mental illnesses, the mental health care facilities available for them are very meagre. There are only **42 mental hospitals** in the country with about **20,000 beds.** More than 50% beds are occupied by chronic patients. In the state of Karnataka, there are two mental hosptials, one in **Bangalore** with 800 beds and the other in **Dharwad** with 300 beds. The number of mental health specialists, also is less. There is only one psychiatrist for one million population, whereas in developed countries, there are 50-150 psychiatrists for every million of population. Recently, psychiatric units have been established in Medical College hospitals and few general hospitals. But it is very important to remember that most of these facilities available in the country are situated in big cities; none are available in rural areas.

MENTAL HEALTH FACILITIES ARE AWAY FROM PEOPLE

Most people do not make use of the available facilities. It is estimated that less than ten per cent of patients who need help, take modern treatment. Majority of our patients remain without getting help because of ignorance, fear, stigma, misconceptions and faulty attitudes regarding mental illnesses, their causes and treatment. They believe that mental illnesses are caused by evil spirits, black magic, witchcraft, bad stars and bad deeds in the present or past life. Therefore they seek the help of **faith healers, mantravadis** and magicians who perform puja, counter-magic, exorcism, or offer

prayers to gods and give native/herbal medicines. They do not know that modern doctors can treat mental illnesses satisfactorily.

- ★ People have their **own fears** about mental hospitals. They believe that mental hospitals are places where dangerous mental patients are locked up. They would not like their relative to be kept in such a dangerous set up. An ex-inmate of a mental hospital and his family members are socially isolated and stigmatised. Therefore people think of mental hospitals as the last resort.
- ★ **Distance :** Since there are only one or two mental hospitals in most states, which often very far away for majority of the needy persons and their families.
- ★ **Poverty,** lack of support : In our country many are poor and do not have money or other help to take the patient to the hospital or buy medicines.
- ★ **Long term treatment and follow up :** Some patients need medications for a long time. They have to consult the doctor periodically. Almost all the epileptic patients need drugs for 3-5 years. Most rural patients find it difficult to come even for the first consultation and treatment. They become very irregular and even stop the follow up visits to the hospital. They come again if there is a relapse. They lose faith in hospital treatment and become victims of healers who claim instantaneous, quick relief or cure with their treatment. When patients do not improve, the attempts to treat him are given up with frustration and helplessness, as untreatable.

BASIC MENTAL HEALTH CARE PROGRAMMES

The major experiments in organising basic mental health care programme have been at Chandigarh and Bangalore. Both these centres aimed to integrate mental health care at primary health care level.

The **Chandigarh programme** carried out at the Raipur Rani Block of Amabala District of Haryana state (1975-1982) was part of a WHO project. Efforts were directed to develop the system of priorities to train the existing primary health care personnel to carry out basic mental care tasks and to involve the community through public education and formation of a mental health association. 60,000 population of a PHC block was selected for the work. Over the course of 6 years, the limits for mental health care work at primary health care level was outlined. The results have demonstrated that there are significant number of mentally ill living in the rural areas needing urgent treatment and currently not receiving any help. Further it was possible for the different categories of health workers to carry out a limited range of mental health activities with the support of the medical officers. It was also possible to involve the community in a meaningful manner. This experience has resulted in a practical 'Manual of Mental Disorders' and health education materials.

A simultaneous project was carried out at **Bangalore** by the Community Psychiatry unit of Dept. of Psychiatry, National Institute of Mental Health and Neuro Sciences (NIMHANS) Bangalore from 1975. In a series of planned studies and training programmes it was noted that it is possible to define clear tasks for doctors and health workers working in the PHC system and provide training to them Separate manuals for the multipurpose workers (MPWs) in Kannada and the medical officers in English are available now which outline the experience of the many years of field work. Majority of the above rural mental health programmes were carried out from the Sakalawara Centre in Anekal Taluk. In addition the Solur PHC set up was also involved in the application of the knowledge gained. The experience in these PHCs have shown the urgent need for taking mental health care to villages and the vital role the multipurpose workers and medical officers can play in the service.

But these projects used relatively inexpensive and a limited range of medicines for treatment. The range of drugs needed is only 4 to 5.

TRAINING FOR DOCTORS AND MPWs IN KARNATAKA STATE

A positive development in the State of Karnataka has been the initiation of regular monthly training courses for medical officers and MPWs at NIMHANS, Bangalore since April 1982. The training programme, is of one to two weeks duration and is a residential one. During the training, with the help of classroom teaching, field work, clinical demonstrations and manuals, the basic mental health knowledge and skills are provided

This one week programme for MPW's and two week programme for doctors is going on **every month** since 1982 at NIMHANS. In July 1985, the programme to cover a whole district (Bellary) of Karnataka has been taken up by the joint collaboration of Department of Health and Family welfare, Karnataka, NIMHANS and District authorities of Bellary.

Besides Chandigarh and Bangalore, other psychiatric centres taking up similar rural mental health programmes are Baroda, Calcutta, Delhi, Hyderabad, Jaipur, Lucknow, Patiala and Vellore. Plans are being finalised for this work to be initiated in Haryana, Himachal Pradesh, Punjab, Madhya Pradesh and Pondicherry from Oct. 1985.

NATIONAL MENTAL HEALTH PROGRAMME FOR INDIA (1982)

Following the experiences of different centres in providing community care for the mentally ill, the professionals and planners formulated a programme for mental health at the National Level in 1982.

The objectives of the programme are :

(i) To ensure availability and accessibility of minimum mental health care for all in the forseeable future, particularly to the most vulnerable and under-privileged sections of population.

(ii) To encourage application of mental health knowledge in general health care and in social development.

(iii) To provide community participation in the mental health service development and to stimulate efforts towards self-help in the community.

The **Central Council of Health and Family Welfare** in its meeting held on 18-20, August 1982 recommended that : (i) Mental health must form an integral part of the total health programme and as such should be included in all National policies and programmes in the field of health education and social welfare; (ii) realising the importance of mental health in the course curriculae for various levels of health professionals, suitable actions should be taken in consultation with the appropriate authorities to strengthen the mental health education components. **The planned approach is to integrate mental health services with existing general health services**.

In this introduction we have considered the current state of mental health services in the country as well as the current approaches to the provision of basic mental health care. At present we have a practical and an appropriate approach to provide the needed services. What is needed is its applications through professional commitment to further this area of work and the political and administrative support along with public involvement to make it a reality. Such a joint effort can result in meaningful basic mental care to most of the population, with minimum of inputs and within a reasonable period of time.

II Brain and Behaviour

Man can think. He can remember his and others experiences and suitably react depending on the situations. He can analyse the problems and find solutions. He can logically construct new ideas. He can understand his environment. He can express appropriate emotions. He can have control over his desires and sexual activities. He decides what is good for himself and his family. He can lead his life in such a way that it is comfortable. He can understand whether he is healthy or ill. He knows his limitations. He has meaningful goals and works to reach them. Thinking, decision making, memory, intelligence, emotions, control over one's talk and behaviour, awareness of surroundings are different functions of the mind. Mind is the active part of our 'self' and is the source for all our activities.

Every organ in our body has a specific function. Brain is the organ which carries out all the functions of the mind. Brain of an average man weighs about 1250 gms. It is made up of millions of nerve cells and connective tissue.

Brain can be divided into 3 parts:

1. Brain stem
2. Limbic system
3. Cerebral cortex

Brain stem is responsible for the primary functions of our body - respiration, heart/pulse rate, blood pressure and consciousness. Damage to the brain stem can lead to loss of consciousness and even death.

The **limbic system** controls and guides emotions and sexual activities.

The **cerebral cortex** is responsible for thinking, memory, social behaviour, speech, language, decision making, perception and all behaviour.

Different parts of the cerebral cortex are responsible for these functions. For example: Frontal lobe for thinking and social behaviour. Damage to this part leads to disturbed thinking and socially unacceptable behaviour like urinating in front of others, becoming naked etc. Occipital lobe is related to visual perception. The temporal lobes are involved in hearing and smell. Parietal lobes control movements of the body and sensory perceptions.

There are relative differences in the way the two parts of the brain, namely left and right parts of the brain function. The left part of the brain guides thinking, speech,

language, ability to master technological issues while right brain is responsible for the abilities to know the position of articles in space, music, dance other artistic abilities, emotions and spiritual thinking.

Working Unit of Brain

Brain consists of a large number of units called the **nerve cells.** Each nerve cell is connected to many other nerve cells. These nerve cells are always active whether an individual is wide awake or asleep; whether resting or working. Their activity is of a chemical and electrical type. By placing electrodes on the scalp, these electrical activities can be recorded on paper by a special technique. This recording is known as electroencephalogram (EEG). By studying the EEG in health and during illness, experts have made attempts to understand the mode of functioning of the brain in various conditions.

The space between nerve cells where one nerve cell ends and another begins, is known as **'synapse'.** When a 'message' reaches the end of the nerve cell, it stimulates pockets of chemical substance and releases it into thé synapse. This chemical substance which is called **'Neurotransmitter'** acts like a bridge and helps the message to reach the other cell. When an individual thinks, talks, or does anything, many such neurotransmitters are actively involved.

As long as these neurotransmitters are produced, released and function adequately, the brain functions normally. If there are changes in these substances, the functioning of the mind gets disturbed. For example, decreased amount of noradrenaline or serotonin leads to depression. Hypersensitive dopamine system is believed to cause psychotic symptoms. Thus such biochemical changes are the cause of many severe types of mental illness.

Poor blood supply, haemorrhage or use of toxic subtances and intoxicating drugs can produce damage to the nerve cells. In old age, nerve cells gradually degenerate. In all these conditions, the abilities of the brain and mind are diminished.

Development of Brain

Nerve cells appear in the foetus of 4 weeks and form a tube. The end of this tube towards the head, enlarges and grows into the brain. The brain of a newborn baby is sufficiently developed and that of a two years baby is almost equivalent to the brain of an adult in its total nerve cells. Protein is very essential for the growth of the brain during these periods. Thus, if there is undernourishment and protein deficiency during the intrauterine life and first two years of life brain development suffers and this can lead to mental retardation. Enough care and attention has to be paid for

providing nutritious food to the pregnant mother and the child to facilitate optimum development of the brain. In this way the development of brain is more sensitive during these age periods than other organ systems.

The brain of the new born child is functionally immature. The child can express few emotions like fear and react to frustrations by weeping. Except for basic skills like sucking, swallowing, bowel-bladder movement, reflex actions, the new born child is dependent on the mother for survival. As the child grows, the various mental functions develop. The child gradually learns to think, to remember, to understand the environment, to talk, to behave appropriately in different situations, to take decisions and acquire various skills like dressing, reading, writing, solving problems and control over biological functions.

PARENTAL ROLE

To begin with, the child observes his parents and others activities and tries to imitate them. Children retain and repeat the activities which are appreciated and encouraged by the elders and give up those activities which are not approved by them. **Thus parents, others and the family environment shape the mental functions of the child.** A child who gets proper love and affection, encouragement and guidance from the elders grows well and develops skills which are essential for successful living. Children learn to control the desires and to respect social and moral restrictions. On the other hand, a child who is pampered or serverly punished or not cared for or has inadequate models learn the essentia! skills to live. Such children can develop faulty attitudes and behaviour. In later life he/she is unable to face day to day problems of living. He/she becomes dependent on others and remains generally unhappy. Such persons tend to develop different mental illnesses when confronted with problems.

The process of learning appropriate behavioural skills and modifying the wrong ones continues throughout the life of the individual. The process is dependent on the abilities and needs of the individual, expectations and reactions of the people and socio-cultural factors.

STRESS

In the last two decades research has demonstrated the strong association between life stresses and emotional disorders. Stresses can be of varying intensity from the ones like problems at work, personal misunderstandings, move from one place tc another or severe ones like death, divorce or loss of job. In addition, they can also be experiences like natural disasters like floods, earthquake or man made disasters like accidental fires, collapse of a dam or leakage of toxic material from factories.

All these stresses affect the mental health of the individual. Individuals going through a stressful period experience enhanced feelings of sadness, anxiety, irritability, hopelessness and present to doctors with physical problems of poor appetite, weakness, sleeplessness, decreased sexual interest and bodily pains. These complaints can be the starting point of physical problems when stress is prolonged (eg: hypertension, peptic ulcer, myocardial infarction).

Thus, behaviour of an individual is the net result of his body constitution (genetic, growth and development of the brain) his psychological make up (experiences, knowledge, attitude etc.) and environmental factors (family, social and cultural norms). Each behaviour can be understood in the background of these three areas.

For example: (i) Hyperactivity or underactivity of a mentally retarded child is related to the poor development of the brain, (ii) temper tantrums of a child can be due to improper attention given by the parents, (iii) shouting of a person towards his subordinates can be the result of anger and frustrations, (iv) expression of socially not accepted ideas, behaviour and beliefs by individuals can be the result of changes in his frontal lobe or other parts of the brain, (v) antisocial behaviour of an individual can be the result of brain damage or reactions to problems in personal life or a reaction to social oppression, (vi) severe emotional reaction of an individual can be the result of his past experiences or poor social supports.

Thus when individuals are brought with unusual, abnormal and unwanted behaviour, it is necessary to understand their behaviour from different aspects of the individual namely the biological factors, early life experiences, current life situation, social and cultural factors.

III Mental Disorders
(Features, Types, Causes and Treatment)

WHAT IS MENTAL ILLNESS?

All of us get emotionally disturbed at some time or the other, due to a variety of reasons. Sometimes we feel sad while at other times behave peculiarly, in response to certain situations. Often, these responses do not last very long. Our routine day to day functioning does not get disturbed and others are generally not affected in any significant way. These day to day changes are not considered to be abnormal. We would pass them off as 'off moods' emotional upset', 'losing temper', etc.

What is mental illness? When can a person be considered mentally ill?

THREE CHARACTERISTICS OF MENTAL ILLNESSES

1. Abnormal changes in one's thinking, feeling, memory, perceptions and judgements resulting in changes in talk and behaviour.
2. These changes cause distress and suffering to the individual or others around him or both.
3. The abnormal changes and the consequent distress cause disturbance in day to day activities, work, and relationship with important others (social and vocational dysfunctioning).

For example: Most students become anxious at the time of examination. They are worried whether they would pass and are afraid of the consequences of failure. But majority of them go to the examination. Only few become so anxious that they cannot study. They complain that they forget whatever they read and stay back from the examination. They do not get satisfactory sleep. They become more and more worried about their difficulties.

It is but natural for a mother to feel sad when her child dies. She may not eat properly, sleep well or show interest in anything. She reconciles and starts attending to her day to day work within 3 to 4 weeks. But if she continues to feel sad about the death, weeps, neglects the other living children, and the household chores, for months her sadness becomes abnormal.

Sometimes we don't get sleep and we may not be able to eat properly due to poor appetite. When we strain ourselves or think too much, we get headache and feel exhausted. Since these last only for short periods of time usually, we are not worried. But if they recur often and last for longer periods of time they can become disturbing. They could be considered as 'illness'.

Therefore, for a person to be considered mentally ill, he should have symptoms which bother him and/or others around him and disturb his daily routine.

FEATURES OF MENTAL ILLNESSES

1. Disturbances in bodily function

a) **Sleep:** The patient finds it difficult to get sleep. He lies on the bed or sits and worries for not getting sleep. He wakes up in the middle of the night and fails to get sleep again. He has disturbed sleep throughout the night, or he does not sleep at all. He is not fresh in the morning. Any of these types of sleep disturbances can be present.

b) **Appetite and food intake:** Patient does not have appetite and eats less or although he has appetite he does not relish what he eats. He loses weight too.

c) **Bowel and bladder movements:** Patient passes urine more frequently than before. He has loose-motions or becomes constipated. Some patients soil their clothes. They remain unaware of it.

d) **Sexual desire and activity:** Patient loses interest in sex. He can become impotent too.

2. Changes in mental function

a) **Behaviour:** Patient behaves peculiarly in a bizarre way. His behaviour irritates his family members and others or puts them into very awkward situations. His behaviour can be dangerous to himself or others. He can be overactive, restless, and wander aimlessly. He abuses and beats others for trivial or no reason. (EXCITEMENT)

In contrast to this, he can become very dull, show no activity and sit or lie down for hours or days refusing to move even to attend to his bodily needs (Retardation, Stupor). He can move the different parts of his body in a funny way and become a source of concern to others.

b). **Talk:** (and thinking): Patient talks excessively and unnecessarily or he talks very little or stays mute. His talk becomes **irrelevant** and ununderstandable (incoherant). He expresses peculiar and wrong belief which others do not share. For example, patient can say that somebody is pumping poisonous gas into his eyes, thousands of worms are crawling under his skin or every food article served to him is mixed with poison (delusions).

c) **Emotions** (Feelings): Patient can exhibit excessive emotion (elation, sadness), inappropriate emotions to situations or he can not express any emotion at all. He sits like a statue, laughs and weeps to self, without any reason. (incongruous emotion)

d) **Perception:** Patient can have disturbances in understanding various stimuli reaching him through the five senses. He misinterprets them. He hears sounds that others do not hear and says that his enemies are coming to kill him. He sees figures on the wall and says that it is a devil (Hallucinations).

A mentally ill person can see things which do not exist or which are not seen by others. He can hear voices from nowhere. He has spurious sensations of the skin. Thus without any external stimuli, he perceives things and reacts to them. This is known as ''hallucination''. For example, when the patient hears some abusing voices, he may inturn start abusing or threatening the imaginary persons. When he sees some people with dangerous weapons he may run or attack people. A patient who is hallucinating, is seen talking to self, laughing or weeping to self, wandering in the streets, and arguing or behaving abnormally.

e) **Memory:** Patient can lose his memory and start forgetting important matters. He forgets what he sees, hears or experiences a few minutes earlier. He cannot remember where he has kept his pen, spectacles, umbrella etc. He cannot remember the transactions made a few days ago and people he met a week earlier. He can lose his past memory and find it impossible to recollect the names of his children, where his brothers and sisters live etc. He can lose his way in a familiar place.

f) **Intelligence and judgement:** In some mental illnesses, intelligence and the ability to take decisions deteriorate. Patient loses his reasoning skills and abilities. He makes mistakes in his routine work. He is not able to do simple arithmatic and reacts like a dull person.

g) **Level of consciousness:** In some mental illnesses, due to possible brain damage there can be changes in the level of consciousness. Patient fails to identify his relatives. He can be disoriented to time and place. (Disorientation)

3. Changes in individual and social activities

Individual: Patient can neglect his bodily needs and personal hygiene. He does not wash his face, comb his hair, shave, take bath, change his clothes etc. He remains unclean. He does not bother even when things cause pain and discomfort. He can soil his clothes and bed.

Social: He can behave strangely with his family members, friends, colleagues and others. He can insult them, abuse and assault them. He can behave in an inappropriate manner in social situation and embarass others. He can behave rudely so that others get annoyed with him or make fun of him. (Lack of social sense)

Types of mental Illness

There are different types of mental illnesses. Some are severe and some are mild in nature. Mental illness can be broadly grouped into

1. Severe type of mental illnesses (Psychosis) Schizophrenia, Manic Depressive Psychosis, Organic Psychosis.
2. Minor type of mental illnesses (Neuroses)
3. Other disorders: i) Mental Retardation ii) Childhood behavioural problems iii) Epilepsy

Psychosis: It is a severe type of mental illness in which patients talk and behave abnormally. The functions of the body and mind are severely disturbed resulting in gross impairment of individual and social activities. He loses touch with reality and people lable him as ' mad' . He is not aware of his illness and often refuses to take treatment.

Psychosis sometimes can be associated with known physical illnesses like diabetes, high blood pressure, tuberculosis and various other diseases affecting the brain.

Neurosis: It is mild type of mental illness wherein patients show either excessive or prolonged emotional reaction to any given stress. They have symptoms like anxiety, fear, sadness, vague aches and pains and other bodily symptoms. They are aware of their problems and seek help.

Childhood behavioural problems: These are mostly disturbances of behaviour and conduct occurring in stressful family situations. They are mostly short lasting conditions.

Epilepsy: It comes in attacks in which the patient loses consciousness, falls down and has rhythmic movements of the limbs. Children and young adults are more often affected.

Mental Retardation: These persons have decreased mental abilities and cannot adjust like normal persons. Thus they are disabled to varying extent.

CAUSES OF MENTAL ILLNESSES: Mental illnesses can present in a variety of ways. They are caused by a variety or reasons.

1) **Changes in the brain:** Any change either in the structure or functioning of the brain can give rise to mental illness, biochemical changes at the level of nerve cells are the cause in majority of the severe type of cases (psychoses). Here brain looks normal on examination.

   Damage to the structure of the brain by any of the following reasons, can also cause mental illness.

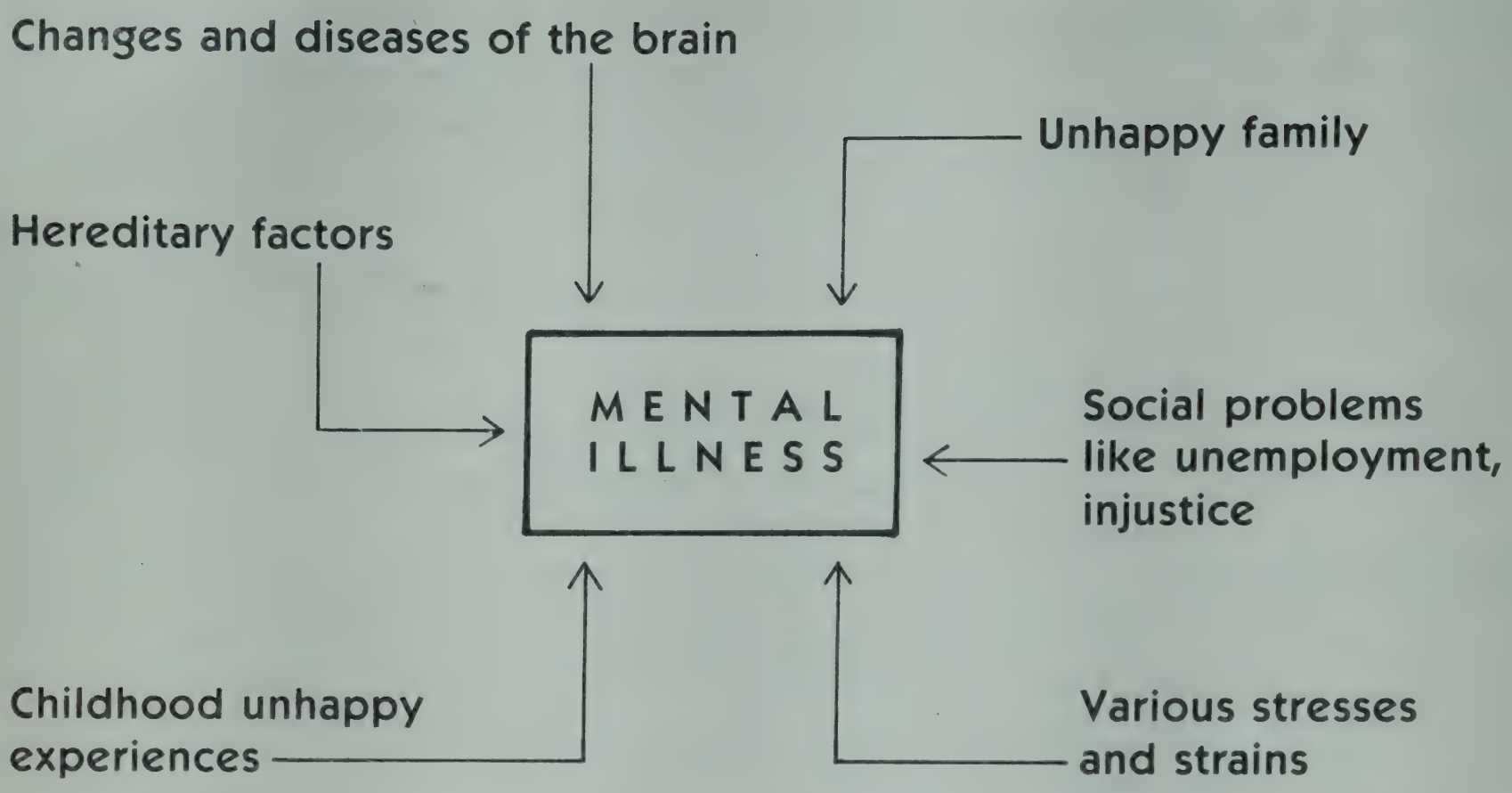
   a) Infections b) Injury c) Poor blood supply d) Bleeding e) Tumors e) Alcohol intake for long periods g) Nutritional deficiencies h) Untreated fits i) Degenerative diseases

2) **Hereditary factors:** In few cases of mental illnesses, there can be some one in the family suffering from a similar illness. But in most cases, there would not be anybody in the family who has mental illness. The proneness for developing mental illness is transmitted to an individual but whether an individual would actually manifest the illness depends on many other factors.

3) **Childhood experiences:** Proper love, affection, suitable guidance, encouragement and discipline are necessary for healthy growth of a person. If they are not available and there are repeated unhappy experiences in the childhood, they can also lead to mental illness in later life.

4) **Home atmosphere:** Frequent quarrels, misunderstanding among family members, lack of warmth and trust among them can have untoward effects on the person. Such a person when faced with stress and strain can breakdown as he lacks the skills to adjust and control his emotions.

5) **Special factors:** If an individual does not get fair opportunities and facilities to live in a society, he suffers and can develop mental illness. Poverty, unemployment, injustice, insecurity and severe competitions can result in mental distress.



TREATMENT OF MENTAL DISORDERS

We have noted that mental disorders are of various types. They affect the individual to varying extent. They can be of short duration or of longer duration. The treatments available are varied. It is often thought that no specific treatments are available. **THIS IS NOT CORRECT.**

This wrong notion arises as people generally think of mental hospitals where people often stay for life, or visualise the chronically ill persons only. **Since 30 years we have specific treatments for chosen mental disorders which are as effective as are treatments for physical illness like tuberculosis, leprosy, malaria and typhoid fever.**

The different types of treatments available are

(1) **Medicines:** These are most suitable for the treatment of acute cases of severe mental disorders, commonly called psychoses, and epilepsy. With starting of treatment early and regularity in its use, a complete cure can be obtained. These are available as tablets, injections and capsules.

(2) **Electro-convulsive therapy (ECT):**Commonly thought of as the main treatment for all mental illnesses is another method of treatment for severe mental disorders. When used in **selected patients,** it can bring about dramatic improvement as in severe depression.

(3) **Psychotheraphy:** As has been considered in earlier sections, persons in situations of stress experience psychological distress. Such persons can be helped by simple methods like listening to their difficulties, talking to the family as a group, bringing about changes in the living situation to bring about greater harmony in their life.

(4) **Rehabilitation:** Persons with (chronic) long standing illnesses cannot be completely cured and continue to behave and live differently from others. Such persons also benefit by simple measures like involving them in recreational activities, teaching them simple repetitive type of jobs (basket making etc.) and not excluding them from ordinary life. With love and concern much improvement can be brought about in these cases.

The above is a brief account of the treatment methods. More detailed descriptions are included under the individual disorders as well as in Chapter IX

IV History Taking and Mental Status Examination

Establishing a satisfactory doctor - patient relationship is very essential for successful assessment, diagnosis and management of patients with emotional problems. While the quality of the doctor - patient relationship is important in all disciplines of medical practice it is perhaps most crucial in primary health care and care of the mentally ill persons. The ultimate success of this relationship is determined by what occurs between the doctor and the patient. This largely depends on the doctor's ability and skill to convey their interest and warmth to their patients as they listen to the patients problems, thus building up rapport and a relationship of trust. Most of you are trained to investigate, diagnose and treat 'diseases' in organ systems of the body rather than listen to and provide help to emotional problems.

It is well known that a large proportion of people who consult medical practitioners for various bodily complaints have associated mental or emotional problems. Many persons with bodily complaints may not have any physical illness but an emotional problem. Thus more patients with mental illnesses are seen by doctors who are not psychiatrists than by specialists. In spite of this awareness, very little is taught during their medical studies regarding mental illness, interviews skills and treatment of emotional disturbances by methods other than drugs. Therefore, it is necessary to review ones ability to interview patients who may have various kinds of emotional problems to obtain an appropriate history, examine their mental status, arrive at a probable diagnosis and initiate their management.

General reactions to mentally ill persons

As a first step, it will be worthwhile to consider your own emotional reactions to the mentally ill as these reactions will directly or indirectly reflect on your approach to these patients. In the previous chapter you noted that mental illnesses are broadly divided into two groups namely psychoses which are the more severe disturbances and neuroses which are minor psychiatric problems.

When you come across a **severely disturbed mentally ill** (psychosis) patient, your emotional reactions are likely to be one of the following 1) Fear and apprehension that he may be harmful, 2) dislike and disgust because he is dirty, 3) anger and rejection because he is arrogant and he annoys you, 4) sympathy and pity as he is suffering, 5) amusement and laughter due to his childish/funny behaviour, 6) distrust and disinterest as he is not reliable.

You may try to keep him away or keep yourself away from such patients. Even if you are interested in helping him, you may not know how to talk to him and treat him. Either disinterest or ignorance will make you develop an attitude of ' why should I bother, he is after all a mad-man, let me refer him to the mental hospital/mental health specialists' .

With patients of **minor mental illnesses, (Neuroses),** your reactions are likely to be different. In the first place you may have difficulty in identifying them. But if you have identified some of them from your regular patients you may be dissatisfied with their treatment response. Their persistent somatic complaints, repeated visits to the clinic and their tendency to cling or linger on may make you dislike them. Some of their complaints may puzzle you because they are multiple, apparently vague and diffuse. Detailed physical examination and investigations may not reveal any abnormality. Sometimes even when you know that a patient attending for somatic complaints has psychological problems, you may have difficulty to change your approach from precise and concrete physical signs and symptoms to psychosocial factors and manifestations.

Approach to mentally ill persons

Most patients including the severely disturbed are capable of understanding their doctors' reactions and responding to them accordingly. Our effort initially should be to establish a good doctor - patient relationship. All patients need to feel that their doctor is genuinely interested and concerned about them and is willing to listen to their problems attentively and carefully. Ask yourself whether you have a genuine desire to help the patient and whether you are communicating this' interest to the patient.

How can your interest and concern for the patient be communicated? Listen carefully to your patient and give him an opportunity to express his problems as spontaneously and fully as possible with least interruptions. Maintain eye contact with the patient as much as possible. Acknowledge and respond to what the patient says verbally and/or non-verbally (gestures like nodding). Do not convey your constraints of time and your being in a hurry. You have to be sensitive to the emotional distress of your patient.

You have to be very careful about your own emotional reactions, while approaching a **severely disturbed patient.** You should recognize their reactions and make every effort to moderate them. When you show trust, respect and concern for the severely disturbed they, in turn will trust you and follow your instructions. The mentally ill person is a human being with his own feelings, thoughts, likes, dislikes and self respect. You should remember that he expects to be treated as a responsible and respectable individual and hence treat him as one who is suffering and needing your understanding

and help. Do not do anything to degrade his self respect and give due importance to him. Do not comment, confront, criticise or laugh at your patient. Try to understand what the patient has to say and do not deny the reality of the patient's experiences. You need not agree to all his statements but accept them with a neutral attitude. By direct verbal reassurance inform the patient of your commitment to his welfare. It is unwise to consider the patient ' mad and unreliable' and listen to only his attendants.

After the patient's description of his problems, talk to his relatives. If there are discrepancies in the information given by the patient and his relative, do not get alarmed but draw their attention to this and request them to clarify. While interviewing patients or their family members, ask only what is necessary and do not ask unnecessary details just to satisfy your curiosity. Do not ask very personal questions or questions regarding sexual matters in front of others. If they are required, try to obtain them when the patient is alone. Assure him that these details will be kept confidential and maintain total confidentiality.

HISTORY TAKING

The general principles of history taking in mentally ill patients are in many respects similar as in general medical practice. The patients' own description of his current problems have to be heard first. His illness has to be understood in the context of his family, job, social and cultural environment. Open ended general questions only should be asked initially. More specific questions can be asked later on after the patient has completed the description of his complaints in his own style. The details of how the patients symptoms started and progressed, (i.e. onset and course) in a chronological order are important. Patients should be encouraged to go back to the time when they were completely symptom free and to relate any possible precipitating or perpetuating stress factors. The degree of severity of the symptoms, their effects on patient's routine daily activities and bodily functions like sleep, appetite and bowel/bladder functions must be enquired. It would be important to know what the patient thinks about his own symptoms and complaints.

The family history and personal history have special relevance in the assessment of mentally ill patients. Family plays an important role in the development of each individual as noted in Chapter II. The causation and manifestation of several types of emotional disturbances can be understood by knowing the composition and the socio-cultural background of the family of the patient. Certain resources in the family could also be made use of in the management of the patient's problems. History of mental illness in the family and any inter-personal problems should be enquired. The personal history ideally should be a biographical account of the patient indicating significant events from the time of his birth till the present date. It should include patients early development, childhood, schooling (and educational attainments) work

(occupation) and marriage. The nature of work and the effect of illness on work should be assessed. The completed history should contain information about any past physical or mental illness. An attempt must be made to know what kind of a person the patient was before the onset of the illness. In short, the history taking should be an effort to understand the patient as a whole, and not just aimed at obtaining the details of his symptoms.

Mental status examination

As has already been mentioned the major approach to diagnosis and subsequent management of mental illnesses consist of observation of the patient, conversation with the patient (interviewing) and their interpretation. Unlike other disciplines of medicine, where special examinations, laboratory procedures and other investigations have an important role in diagnosis, **history and mental status examination are the two important diagnostic tools in psychiatry.**

The mental status examination consists of the exploration and description of the patients appearance, behaviour, talk, mood, thinking, perception, level of awareness, orientation, memory, judgment and his understanding of his own condition. (The various changes which can occur in any of the above mentioned functions have been described in Chapter III. Observations about the mental functioning begins even while taking the history and can continue while doing the physical examination. A physical examination is a must in every patient. Although history taking and mental status examination are discussed separately here, in actual clinical practice they are generally combined.

It must be remembered that for mentally ill persons the treatment process begins with the very first history taking interview itself.

V Major Mental Disorders (Psychoses)

Each of us is very individual in our own way. We have different interests and methods of dealing with different situations in life. Similarly our behaviour is also not uniform. However, most of us in a community have fairly similar ways of thinking (mentally reacting), feeling and behaving. In all communities there are agreed norms as to what should be considered normal and what should be considered abnormal. A major shift from commonly accepted behaviour is considered 'ABNORMAL'. For example, nobody will consider the wearing of different coloured dresses at a village meeting or a fair as abnormal, but anyone coming naked will be immediately considered as being abnormal, by almost all persons.

In medical sense, any persistent and severe disturbance of thinking, feeling and behaviour is considered abnormal. In the past such conditions were called 'insanity'. Modern science classifies them as PSYCHOSES. In popular language sufferers from such illnesses are often wrongly referred to as 'mad' or 'insane'.

Till recent times, persons with severe mental illness were feared and managed harshly by tying up, chaining or locking them in a room. Some persons also considered them holy and cared for them with respect. **Since 30 years medical treatment is available which can make these ill persons normal so that they lead a normal life.** The following section deals with persons having PSYCHOSES - their recognition and care. It is estimated that 5-6 persons in 1000 population suffer from one or other form of psychoses.

WHAT DO PEOPLE THINK ABOUT PSYCHOSES

It is a common belief among less educated persons that psychosis is not an illness. It is thought to be due to religious and supernatural forces. This is attributed to phenomenon like 'illwill of Gods' and 'visitation of evil spirits and souls of dead persons'. As a result of these beliefs persons with psychosis are usually taken to religious healers magicians, temples instead of medical facilities. It is also thought that there are no medical methods of treating psychosis.

It is very important to recognise and remember that psychoses are similar to other physical problems in that persons can recover from them as much as from other physical problems. As in the case of all disorders the outcome with treatment varies with the severity and type of the problem.

IMPORTANCE OF CORRECT TREATMENT

The importance of treating and caring for those with psychoses arises from the problems that such persons can cause to themselves and others. Excited persons can destroy property and hurt family and friends. As a reaction to their altered thinking and feeling they can destroy themselves as well as stop taking care of their responsibilities at home and work. The additional factor of social embarassment and loss of productivity is also important. When not treated early, some of them become chronically ill and need to be taken care of for the rest of their life. It has also been noted that many marriages break due to an acute attack of psychosis. For these reasons it is important to RECOGNISE PSYCHOSIS EARLY AND GIVE CORRECT TREATMENT.

There are two main types of psychoses: 1. Functional Psychoses, 2. Organic Psychoses.

1. Functional Psychoses are forms of psychoses where there are no detectable abnormalities in the structure of the brain or other organ systems of the body. In **organic psychoses,** symptoms are the result of disturbances in the brain (infection, trauma, tumour etc.) or disturbances in the other body systems (congestive failure, pneumonia, uraemia, hepatic failure etc.)

The different types of Psychoses and their management is considered in the following section.

1. FUNCTIONAL PSYCHOSES

There are two types of functional psychoses namely:

1.1 SCHIZOPHRENIA

1.2 AFFECTIVE PSYCHOSES

1.1 SCHIZOPHRENIA

Some case histories will illustrate the schizophrenic illness:

Mr. PAPU is a 21 year old man from a rural area who completed his primary school and started assisting in the agricultural work of his family. He was a quiet and calm person with only few friends. His relationship with others in the family and village and his work was condsidered satisfactory. Since the last few weeks, he has been quiet and withdrawn, not caring to talk to others, even at home. He has not been working well too. He looks different, as if he is in his own world, not aware of what is going on around him. He is irritable, sleepless and doesn't take his food regularly. On enquiry, the relatives mention that, he mutters and smiles to himself. His answers to questions put to him do not make any sense

(inappropriate and ununderstandable). At times he acts in a very strange manner. He looks at the roof and gesticulates, sometimes he looks scared. He has been neglecting his personal hygiene. On talking to him, he reveals that his thoughts and actions are controlled by some external force. He hears commanding voices ordering him to do certain things. Parents report that there have been no life changes preceeding the onset of illness.

Mr. Satish, is a 24 year old male. He has been reported to be talking and behaving strangely since last several days. He is restless and hostile to people around him. He abuses them and even attempts to assault them when he gets irritated. He does not sleep at night. He keeps talking to himself and shouts at times. He has stopped working. **On enquiry** the relatives mention that he is unduly suspicious of everybody and everything around him. He says others are talking about him. He believes that people stare at him and watch his actions. He suspects that few of them are plotting to harm him and destroy him. He hears the conversations of these people who are against him. Some of them are people known to him while others are strangers. Sometimes he hears his own thoughts as if somebody is shouting from somewhere. At other times he can hear a running commentary of his own actions. Because of these experiences, he is scared to move around.

Mrs. Poonam, is a 34 year old married female who has been deserted by her husband and presently living with her old parents and brother. She has been ill for the last 5 years, with several episodes of exacerbation of her symptoms. She has never been completely well at any time during this period. Her illness started few years after her marriage. Her relatives are unable to give details of the onset and progression of her symptoms. Presently she does not do any work regularly. She eats and sleeps as she likes. She stays at home and in her village for few days of the month while at other times wanders and begs around in the near and far off villages. She is known as a ' mad woman' by every body including the children of these villages. After she became sick, her husband had taken her to various popular healers but she continued to be ill. He sent her to her people who now believe that there is no treatment for her 'madness'.

The above three examples are of a mental illness called **'SCHIZOPHRENIA'.**

Schizophrenia is the commonest of the psychoses and it's symptoms closely correspond to the layman's concept of madness. It is an illness which interferes with the individual's personal and social functioning and if untreated, runs a chronic course. Schizophrenia usually starts in the age group 15-25 yrs. The onset can be acute or insidious. Sometimes the onset may be precipitated by a stressful event. The illness generally runs a continuous and chronic course.

The illness is characterised by abnormalities of **thinking, perceptions,** and **emotions** resulting in abnormal behaviour, action and talk. The schizophrenic has abnormal ideas and thoughts of various kinds which he firmly believes and are unshakable (delusions). He perceives things which really do not exist (i.e. he hears voices and sees visions which are non-existent - hallucinations). He misinterprets the environment and has special meanings for various things of normal occurrence. He may be unusually happy or sad inappropriately or apathetic and unconcerned. Because of these, his talk and actions might become ununderstandable and irrelevant. He may either talk too much or too little (or not talk at all). He may be found talking and laughing to self. This can be his responding to the voices he hears. He may be withdrawn and inactive or restless, and hyperactive. He may become suddenly hostile, abusive and assaultive in response to an unpleasant thought or voice. Phases of excitement may be followed by phases of extreme withdrawal when patient may remain in uncomfortable and bizarre postures for long periods of time. Varying degrees of sleep disturbance will always be present.

It is very essential to remember that in actual clinical practice, **only some of the above features may be present in any given patient.** But diagnostically one of the most important finding is that the examining doctor usually finds that he cannot share or understand the patient's experiences, and meaningfully communicate with the patient.

Both genetic and environmental factors are important. Factors like intrafamily relationships, socio-cultural factors, severe psychological stresses of any kind are important in the causation of schizophrenia. These factors operate in different combinations and degrees to predispose, precipitate or perpetuate schizophrenic illness in an individual. Although it's etiology is not definitely known, what is certain is that the **causation is multifactorial.** It is currently understood that hyper sensitive 'Dopamine system' (Neurotransmitter) is responsible for the symptoms of schizophrenia.

MANAGEMENT

RECOGNITION: The most important guideline (indicator) for recognition is a rapid (recent) change in someone's personality. The family members and neighbours report that he has become 'a different person'. They no longer understand or share the behaviour and thinking of the ill person.

The more severe cases of acute psychosis are easy to recognise as their behaviour will be very different from others, that is, those with excitement, slowness, suspiciousness, sadness or abnormal behaviour. However, less severe cases can be missed if not carefully looked for as part of routine work in the clinic.

Consider the possibility of psychosis under the following situations:

- ★ When someone is mentioned to have excitement, violent behaviour or socially unacceptable behaviour.
- ★ When someone is talking excessively or does not talk to anyone at all.
- ★ When someone expresses repeatedly bizarre somatic symptoms.
- ★ When someone has stopped working without any clear reason.
- ★ When someone talks of taking one's life.
- ★ When someone complains repeatedly that others are harming him or planning to kill him.
- ★ When someone has sleep disturbance for few weeks.
- ★ When a person has stopped taking interest in his dress and personal appearance.

WHAT TO DO AFTER THE DIAGNOSIS?

Having identified a person with schizophrenia the next step is to evaluate whether he can be managed by you or referred to a centre.

Referral is advised in the following situations

(i) Suicidal risk: Here the person, because of his disturbed thinking and feeling, has shown a tendency to end his life by talking about it or attempting it. This patient should be treated at a centre with hospitalisation facility.

(ii) Danger to others: This is mostly seen in those with acute disturbance in the form of excitement or in those with severe degree of suspiciousness. Also when a person is carrying weapons to protect himself or there is a danger of his losing control and harming others. Treatment to be in a HOSPITAL after giving initial treatment as outlined under treatment.

MANAGEMENT

In most families and communities, the response to a person with psychosis is fear and apprehension. This leads often to overreaction. The commonest way of restraining the person is by physical restraint in the form of tying him to the bed by rope or chains. This step aggravates the patient's abnormal behaviour and a vicious circle of excitment-control-excitement follows.

GENERAL MEASURES

In view of this the steps that need to be taken by you, as the main source of help is to (i) Talk to the patient sympathetically to understand the reasons for his behaviour (ii) listen to the family members and allay their misgivings. (iii) remove restraints if the excitement is not severe and the danger of immediate harm to others or patient is not there. In all cases restraining should be avoided unless the person is very violent. (iv) Taking adequate care of the nutrition of the ill persons (excitement can easily exhaust a person) (v) Keeping harmful weapons, drugs out of reach of the ill person. (vi) See the patient and the family frequently for reassessment.

SPECIFIC MEASURES

A. Acute Schizophrenia (less than 6 months)

Drug treatment can effectively control the disturbances of psychosis. The drug to be used is CHLORPROMAZINE. Chlorpromazine (CPZ) is available as white tablets of 25 mg, 50 mg and 100 mg. It is best to use one strength of the tablet to avoid confusion. the strength of 100 mg is most economical for use.

The initial dose of CPZ should be dependent on the degree of disturbance. For example, for persons with acute excitement requiring restraint a dosage of 300 mg per day (in three divided doses) is most appropriate. For those with disturbance of lesser intensity, dosage of 150 mg to 300 mg is used (in three divided doses).

Initially the response to the drug is often dramatic in that the symptoms subside with drug use. However, after a few days there may be need to increase the drug upto 600 mg per day. If 600 mg per day does not control the disturbance within 2 weeks, please consult a specialist. Similariy, if there is no improvement after 4 weeks of treatment the person should be seen by a specialist.

Most patients respond to 300 mg daily dosage. The improvement is seen in decrease of abnormal symptoms and gradual return to normal routine activities. As the treatment progresses the ill person sleeps better talks more relevantly and takes interest in his family and friends. He also talks less of the odd ideas and does not show ununderstandable behaviour.

The same dosage is also indicated for patients who are brought with extreme degree of withdrawal and other symptoms associated with it. In such patients, while chlorpromazine ensures adequate sleep at night, it can also cause excessive and unwanted drowsiness during the day. Another type of phenothiazine namely

Trifluperazine (Chapter IX) in doses ranging from 10 mg to 15 mg can be given instead of chlorpromazine. This will overcome the side effect of excessive drowsiness during the day. However if this phenothiazine drug is not available, Chlorpromazine in the above doses should be given.

The commonest cause of **recurrence of symptoms** or failure to respond sufficiently to treatment is the failure on the part of the patient (and his relatives) to take the medicines regularly due to various reasons. One of the commonest reasons is the mistaken belief that they are 'sleeping medicines' and are habit forming. This belief needs correction. The phenothiazine drugs do not cause dependence irrespective of the duration of its use.

It is advisable to **follow up** the patient initially, once weekly and later when the symptoms have remitted, once either fornightly or monthly.

From the time of showing improvement the drug needs to be continued for another **4 weeks** at the same dosage. Following this gradually reduce the dosage by 50 mg every week to stop the drug after a total treatment of 6 months.

While decreasing the drug if there is reappearance of symptom, the dosage should be maintained and the help of specialist taken for further management.

Patients Refusing Oral Medication

Chlorpromazine is available as a parenteral preparation. In an acutely excited patient CPZ 50 mg im can be given. It is best given in the gluteal (buttocks) area as deep im injection. If following CPZ 50 mg im patient is not controlled, it can be repeated after an another half hour and later every two hours to a maximum of 200 mg.

If parentaral medication is used in the first few days as primary treatment, because patient refuses oral medication, injection CPZ 50-100 mg can be given every 6 hours. It is best to switch over to oral drugs as soon as patient is cooperative. (Chapter IX B)

Side effect

Chlorpromazine and other phenothiazones are safe drugs but have a tendency to lower blood pressure. So it is advisable to record the blood pressure of all patients started on Chlorpromazine initially. Evidence of liver damage is the only contraindication.

It is important to be aware of and look for side effects of the drug when a patient is started on phenothiazines (Chlorpromazine, Trifluperazine). The commonest side effects and their management is considered under Chapter IX.

Refer an acute schizophrenic under your treatment to a psychiatrist if: i) Excitement is not controlled with in **48 - 96 hours** in spite of using 600 mg of Chlorpromazine per day, ii) If the other main symptoms in a non-excited patient have not come down after 6 weeks of treatment with adequate dosage, iii) If recurrent and severe side effects (dystonic reactions) occur in spite of taking appropriate measure.

Regular drug administration is only one aspect of the management of schizophrenia. All efforts should be taken to rehabilitate the patient as his symptoms start disappearing in response to do some work regularly and the family members counselled to facilitate this. (Chapter IX C)

MANAGEMENT OF LONG STANDING CASES OF SCHIZOPHRENIA

There will be in the community some persons who have had an acute episode of psychosis few years back but are currently having other symptoms. These persons usually do not have the acute symptoms that disturb others, but have other problems like extreme slowness in activities, disinterest in work, lack of emotional feelings for family and friends and inability to take responsibilities. They seem to live in a world of their own. Often such patients have broken homes in the form of divorce, separation etc. They also find it difficult to hold on to regular jobs.

These persons can also be helped by CPZ. The usual dosage is 150-300 mg per day in divided doses. The length of treatment is longer than 6 months. Some persons need to take them all their life to remain well. Along with drugs these persons should be helped to become accepted by the family and society. Finding them simple jobs to rehabilitate them goes a long way in the treatment.

In situations where long-term medication is needed, another phenothiazine FLUPHENAZINE DECANOATE (ANATENSOL) is useful. This is an INJECTABLE drug. It comes as 25 mg per one ml. This drug needs to be given only once is 2 or 3 weeks. This is called a long-acting drug. It is necessary to use regularly antiparkinsonian drug (Chapter IX B) to avoid the occurrence of extrapyramidal side effects.

In chronic schizophrenia, after use of 6-9 months of drugs the dosage of the drug (oral) or the frequency of the injectable drug can be reduced gradually.

1.2 MANIC DEPRESSIVE PSYCHOSES

This type of mental illness is also called affective psychosis because the primary abnormality in this illness is one of 'affect' (affect = emotion, mood). The disturbance in mood occurs both of quality and quantity and ranges from extreme sadness to extreme happiness. The mood disturbance occurs in episodes of either happiness

(mania) or sadness **(depression).** These episodes can also occur alternatingly when the illness is called manicdepressive psychosis (M.D.P). In between episodes the person remains absolutely normal. Each episode lasts for few days to few months and the period of normalcy lasts for few days to several years. A person may get only attacks of mania or only attacks of depression or both alternatingly. By and large recurrent attacks of depression is the commonest manifestation of affective illness and only a quarter of all affective psychoses occur classically as alternating attacks of mania and depression (M.D.P)

Mr. Kamal, a 28 year old clerk in an office, has been talking excessively, for the last 2 months concentrating less and less on his work. He is cheerful, jovial and unduly happy for no obvious reasons. He has become boastful these days and claims that he can do any type of job quite easily without any training. He is friendly and helpful even with people whom he does not know. He talks about various subjects very confidently. He has very ambitious plans for future.

On enquiry his relatives report that he is a nuisance at home. He doesn't sleep at night and keeps doing something or the other. He talks endlessly and gets easily irritated if he is advised or if things don't go the way he wants. He is impatient and restless. He has been spending money excessively. On talking to him it was found that he shifts from topic to topic very soon and cannot concentrate on any topic. He gets easily distracted and irritable. He says that he has special abilities and talents and he can perform various tasks better than others.

This is a typical example of a person with a diagnosis of **'mania'.** The important clinical features are extreme happiness, increased talk and motor activity and high degree of irritability. These symptoms may be very much increased in severe cases of mania. In such cases the talk may become irrelevant and ununderstandable, the person may become impulsive and violent and the condition may be indistinguishable from a schizophrenic excitement. He can be danger to himself and others. Untreated, a manic episode generally lasts upto 3 months after which there can be spontaneous recovery. The frequency of episodes is highly variable - a person can have several episodes during a year or he may have only one or two episodes all his life time.

Mrs. Rani. aged 38 years, housewife with 3 children, is found to be quite for 3 months. She was a very efficient housewife but now she gets tired very easily and finds it difficult to complete the routine household tasks. She is disinterested in keeping the house neat, looking after guests and visiting friends and prefers to be alone. She is disinterested in her own appearance and looks dull and dejected. She has reduced her eating and does not like any food. Most of the time she is found to be worrying and at times cries. She complains of generalized weakness and fears that she is suffering from some incurable illness. On talking to her, she tells that the future is

really hopeless. She feels these are taking place because of bad deeds in the past. She wakes up quite early, by 3 to 4 a.m. and finds it difficult to go off to sleep again. She feels most miserable at this time and has entertained the idea of leaving the house, or committing suicide. Many days she feels better as the day progresses. She believes that death is the only solution to her problems.

Mrs. Rani. suffers from depression. The important **clinical features** are, sadness without any reason, disinterest in everything, sleeplessness, (early morning awakening) and changes in social functioning. In many cases, in addition to some of the above symptoms multiple bodily complaints will be present. In fact, the bodily complaints may be the only presenting complaints. Such persons go from doctor to doctor undergoing repeated investigations without any lasting relief. Some depressives hear voices telling them they are bad and useless and the future is hopeless. They may also firmly believe that ' curse of god' is the reason for their illness or death is the only solution for their problems. While most depressives are withdrawn and retarded, some especially women in their menopausal age may be agitated and restless in addition to being depressed. They may also have extreme degree of anxiety. This is called ' agitated depression'

The other common area of complaints is the biological changes in the body. These are reported as poor appetite, constipation, lethargy, tired feelings throughout the day. PERSONS WITH THE ABOVE TYPE OF DEPRESSION NEED TO BE TREATED ON AN EMERGENCY BASIS. IT IS ESTIMATED THAT ONE IN TEN SUCH PERSONS END THEIR LIFE BY SUICIDE WITHOUT PROPER TREATMENT.

MANAGEMENT OF MANIA

The treatment is chiefly by the use of drugs, namely use of antipsychotic drugs (Chapter IX B).

When the patient is brought in a disturbed and excited state requiring to be restrained, patient can be brought under control with im injection of CHLORPROMAZINE 50 mg. This can be repeated every half an hour till the patient is sedated or to a maximum of 200 mg. Once the patient is sedated and under control oral drugs can be started.

The basic drug for treatment of MANIA is CHLORPROMAZINE. Initial **oral dose** is 300-400 mg daily in divided doses. The clinical condition is reviewed after three days. If there is no improvement with the above dosage, dosage is increased upto 600 mg daily in divided dosage. With this dosage most patients show improvement. At times, if there are short periods of excitement, injection Chlorpromazine 50 mg im can be used.

With the above treatment, initially (FIRST WEEK) patient's sleep improves and the activity

level decreases. Gradually in the following weeks the grandiose ideas and other features of mania disappear.

The daily dosage is maintained for at least 4 weeks after adequate response has been noticed. Following this the daily dosage is gradually decreased by 100 mg per day at a time over 4 to 6 weeks. During this period of decreasing the drug dosage, if there is a relapse of symptoms the preceeding dose is restarted and maintained for another 2-4 weeks and then reduction attempted. Sudden stopping of the drugs is not advisable except when the daily maintenance dosage is less then 100 mg per day. After the initial week, major part of the drug can be given as a single night dosage, which decreases the side effects.

The commonest side effects complained of are drowsiness and extrapyramidal symptoms. Drowsiness decreases with suitably decreasing the dosage of the drug or choosing a drug with less sedative effect. Management of extrapyramidal symptoms is given Chapter IX B.

Referral to a specialist is advisable under the following conditions (i) excitement is not controlled with the above dosage even after one week, (ii) side effects are severe and disturbing to the patient, and (iii) main symptoms of mania have not shown significant change after 6 weeks of continuous treatment.

As in the case of schizophrenia, patient should be encouraged to return to work and assume gradually a normal routine.

TREATMENT OF M.D.P. - DEPRESSION

Antidepressant drugs are the drugs of choice for the treatment of depression. There are a number of antidepressants available in the market (Chapter IX B). **There are no differences in the effectiveness of the different drugs.** They differ in the occurrence of side effects and sedative properties. .Generally, it is best to become familiar with any one antidepressant drug and be well experienced in dosage adjustment and management of side effects. The basic drug of choice is **imipramine HCl.** This comes as 25 mg and 75 mg tablets.

The starting dosage of the drug is 75 mg per day given in three divided doses. All antidepressants take about 7-10 days to provide relief. It is best to tell the patient this aspect or the patient may stop drugs prematurely. At the initial stages, imipramine can produce mild and short lasting side effects like dryness of mouth, constipation and blurring of vision. These should not lead to stopping of the drug. Review the clinical condition at the end of ONE WEEK. If the side effects are not disturbing increase the dosage to 150 mg per day.

With the above treatment patients will gradually show improvement. The initial change will be in sleep, appetite, decreased feelings of sadness. Continue the treatment in full dosage at least for 4 weeks after the improvement has been noticed. Following this, the drug can be gradually reduced by 25 mg per week over 6-8 weeks. If there is a recurrence of the symptoms when decreasing the dosage, the earlier dosage is given and maintained for 4 weeks prior to initiating reduction. The total duration of treatment is 3-6 months.

REFERRAL to a specialist is indicated (i) when at the initial evaluation suicidal risk is considered high (such patients respond to ECT quickly), (ii) when there is no improvement in depression with 4-6 weeks of full dosage of antidepressants (iii) there is recurrent attacks of depression with or without mania (these can benefit from lithium), (iv) depression is associated with other physical problems like hypertension, neurological, cardiological problems, and (v) when there are multiple psychosocial problems associated with depressive episodes. All these situations require more detailed evaluation as well as management plans.

2. ORGANIC PSYCHOSES

Organic psychiatric problems are classified into (a) **acute organic psychosis and (b) chronic organic psychosis** depending on mode of onset.

2.1 ACUTE ORGANIC PSYCHOSIS

It is generally due to the effect of physical illnesses and is usually reversible and transient. The clinical features are altered state of consciousness in the form of disorientation to time, place, person, confusion, unconsciousness or even coma. Fluctuating level of consciousness with episodes of confusion and memory deficits for recent events is noted. Frequently fluctuating mood ranging from acute fear, panic, depression to bursts of laughter or crying can be seen. Quickly changing hallucinations (mainly visual type) and these symptoms are worse at night and show considerable fluctuation from hour to hour. It is commonly seen in children and old people.

The commonest **causes** of this psychosis are infections (pulmonary, urinary, brain and its meninges), injuries (post head injury) drugs (intoxication or withdrawal symptoms with alcohol and other intoxicating drugs), post-epileptic states, hypoglycemia/hyperglycemia, high fever, dehydration, nutritional deficiency states, organ failures (cardiac, hepatic, renal failures) and drug induced (atropine and its derivatives).

Management: Identifying and treating the primary cause energetically is of importance (if facilities for this are not available, patient should be referred to a hospital for specialised care). Admit all these initially for management. Take good history, do physical

examination and basic investigations to identify the cause. Keep the patient in a well ventilated ward. Keep an attendant with the patient round the clock. Treat the cause. Manage the symptoms of restlessness/excitement by the use of chlorpromazine 50 mg-300 mg a day. Take care of nutrition and hydration. Generally the total duration of acute organic psychosis is about 4 weeks.

Chronic Organic Psychosis

Starts insidiously and is progressive. It is generally irreversible. It is more common in people who are 50 years and above.

The clinical picture consists mainly of progressive deterioration of intellectual functions like memory, intelligence and judgement. Changes in the personality (behaviour pattern). Quick fluctuations in emotional responses (lability) and stereotyped repetition of words or actions can be present. As the illness progresses, patient will be unable to take care of his personal needs and hygiene. He may develop symptoms like restlessness, sleeplessness, wandering tendencies and suspiciousness.

Patient may also develop neurological symptoms like fits, weakness or paralysis of the limbs or body, difficulty in speech, vision and lack of coordinated movements. The various types of dementias present with chronic organic psychosis in old age group.

Common causes of chronic organic psychoses are infections (brain syphilis, tuberculosis) repeated injuries to the brain, poor blood supply to the brain (atherosclerosis) untreated/uncontrolled diabetes, hypertension tumors and degenerative conditions (presenile and senile dementias)

Management: These patients need investigations and should be referred to a hospital. Treatable conditions have to be treated after investigations.

Counselling the family members regarding the nature of the illness is essential. Looking after patients nutritional and hygienic needs are very important. Tablets of chlorpromazine in smaller doses, 25 mg to 10 mg or Diazepam 5-10 mg can be given when sleeplessness, agitation are seen. Antiepileptic drug has to be given if the patient is having fits. Any person who develops psychosis for the first time after the age of 50 years, should be examined in detail for the possible evidence of organic psychosis.

VI Minor Mental Disorders
(Neuroses)

Neuroses are a group of minor mental disorders, which are not easily defined. Unlike in psychoses, persons suffering from neurosis do not lose touch with reality and they are able to meet the ordinary demands of every day living. They generally have a good understanding of their problems. While they do not cause much of distress to others (in the family, neighbourhood etc.) they themselves experience varying degrees of personal distress and suffering. Their ability to cope with routine household responsibilities, work and other usual social situations though disturbed to varying extent, usually does not disable the person completely. The disability caused is generally related to the degree of personal suffering the patient experiences.

The basic and predominant features of neuroses are tension, fear or worry. All people get tense or worried from time to time especially when faced with difficult problems. However they are able to cope with the situations and overcome their tensions or worry sooner or later. If the tension and/worry is too much in intensity or if too prolonged, in duration, they tend to interfere with the person' s sense of well being and disturb his normal functioning. Many neurotics basically have feelings of inadequacy and inferiority (lack of confidence) which lead them to perceive common every day problems as difficult and threatening. This constantly produces tension and worry and the neurotic prefers to avoid facing these problems, ultimately ending up with a multiplicity of physical or psychological complaints (symptoms).

In most cases of neuroses, there may be a stressful factor or a recent set back either precipitating or perpetuating the symptoms. It may be in the form of a disturbance in relationship with a person, a family quarrel, an unhappy marriage, difficulties at the work situation, persistent financial problems, serious illnesses or death in the family or a social setback.

It would be easy to recognise that most of us cannot escape suffering from some degree of tension, unhappiness and neurotic symptoms in facing the problems of every day life, at one time or the other. But in the case of the neurotic, these **tensions, worry, unhappiness and the consequent symptomatology become part of his life style, leading to constant feelings of insecurity and a need to cling on to others for support.** The exact clinical presentation of neurosis is markedly variable and differ from one person to another. Some examples will illustrate these problems.

Lakshmi, 30, is married for the last 8 years but has not given birth to a child. Sinc two and a half years she has difficulty in breathing and chest pain. She constantl has burning sensation in the chest and abdomen. At times she is distressed by a fas thumping in the chest. At such times she has intense fear, cannot sit in a place an wants somebody to be with her. She has consulted a heart specialist, who after carefu examination and investigation reassured her that her heart is perfectly healthy. In spit of this, Lakshmi continues to have problems and often visits her family doctor seekin good medicines which can help her.

Raju, 22 years is a tailor by occupation. He has general weakness, easy fatiguabilit and pain in the legs for over a year. The tonics and injections given by various doctor whom he has visited during the past several months have not helped him. He think that his nerves have become weak and doctors have not been able to find out the reasons for it. He suspects that his masturbation and loss of semen in sleep are the causes for his illness. He is worried that he will become impotent.

Savitri, is a 30 years old housewife. Since last few months she is unable to do any household work, feels weak and tired most of the time and complains of heaviness of head, pulling sensation in the neck, back and limbs. She is unable to eat properly and has difficulty to get sleep. She as well as others in her family believe that the cause for all her problems is the tubectomy operation she underwent 6 months back She has been pestering the health worker who presuaded her to undergo the operation and the PHC doctor for good 'tonic injections'.

Lakshmi, Raju and Savitri suffer from Neurosis. Their neurosis is associated with problem of childlessness and misconceptions about seminal loss and family planning operation respectively. Some types of neurosis fall into definite clinical patterns while others do not. The most common types of neuroses are:-

1. Anxiety neurosis
2. Depressive neurosis
3. Hysteria

What causes neuroses? Generally, biological, psychological and socio-cultural factors are considered to be relevant in the causation of neurosis. While it is believed that hereditary and constitutional factors may play a role in the causation of neurosis their exact role has not been clearly delineated. Different theoretical models exist for the description of the psychological causation of neuroses.

Faulty learning in childhood and improper personal growth and self fulfilment due to pathological family and interpersonal relationships and faulty parental models have been correlated to the development of neurotic behaviour in adult life. According

to the theories of a very eminent psychiatrist, Sigmund Freud, who developed a treatment method called 'psychoanalysis' the basic cause of neurosis is the individual's failure to handle the inner desires and impulses which usually elicit anxiety and conflict. These conflicts are generally resolved in the mind by certain mechanisms known as **defence mechanisms.** When these defence mechanisms either fail or are abnormal, neurosis is the result. It has been known that, in addition to the above psychological factors, socio-cultural factors like socio-economic status, race, religion, and technological advances and value systems influence not only the prevalence of neurosis but also its presentation.

Anxiety Neurosis

The predominant feature in this neurosis is a constant feeling of uneasiness, vague tension and apprehension with anxious anticipation of danger (when there is no real threat or danger). This anxiety state is often associated with various symptoms like tightness and beating in the chest, empty feeling in the stomach, shortness of breath, inability to concentrate, forgetfulness, disturbed sleep, nightmares, poor appetite, giddiness, weakness, excessive sweating, sustained muscle tension causing aches and pains, chronic mild diarrhoea and difficulty in making decisions. These symptoms sometimes appear in episodes and then it is known as **acute anxiety or panic attacks**.

On examination an anxiety neurotic can show signs like restlessness, anxious look, tremors of the extremities, tachycardia, increased B.P. and cold and clammy extremities. In chronic anxiety state, the above symptoms and signs fluctuate in their intensity causing remission and exacerbations. The pharmacological management of anxiety is by the use of a minor tranquillizer like Diazepam tablets in a dosage range of 5 mg-15 mg per day in divided doses. Reassurance and counselling (Chapter IX A) along with minor tranquillizers often relieves most of the symptoms of anxiety neurosis.

In a condition called **"Phobia"** (Phobic Neurosis) the sufferer develops intense irrational fear of a specific object or situation, that normally presents no real danger, and actively avoids the object or situation. The sufferer would know that his fear is absolutely silly and there is no reason for fear but still he cannot help avoiding the object or situation. Symptoms and signs of actute anxiety appear, if they ever attempt to approach the feared object or situation.

Depressive Neurosis (Neurotic Depression)

The predominant symptom in depressive neurosis is one of sadness (depression) and worry of varying intensity. Environmental factors causing prolonged stress and strain are invariably present. These may be family quarrels, serious illnesses or death in the

family (or close friends) financial difficulties, difficulties at work. In addition to the changed mood of sadness, the depressed patient also complains of lethargy, weakness, helplessness, hopelessness, decreased or lack of interest in work, people and everything around, lack of confidence, irritability, multiple bodily complaints and disturbances in sleep and appetite. When the degree of sadness increases preoccupation with ideas of suicide is often present and it may be difficult to distinguish this depression from those of manic depressive psychosis. Suicidal attempts must always be taken seriously.

Reassurance, support and counselling coupled with an antidepressant medication like **Imipramine** in doses ranging from 25 mg to 150 mg per day is the line of management. Diazepam should be added to Imipramine, if sleep disturbance is a serious problem. Ultimate dosage of medications is dependent on the response and side effects. (Chapter IX)

Hysteria

In this type of neurosis patient develops typical symptoms of physical illnesses without any evidence of any organic pathology. The illness usually helps the individual to escape or avoid a threatening or stressful situation. The stress or threat need not always be external. It may, arise from the individual's inner conflicts, impulses and desires. The symptoms, in addition to avoiding stress, may also help the individual to fulfil certain needs. They help him to draw attention to significant others in the family and community and gain their sympathies and support. Thus, hysterical symptoms may be considered as a way of communicating distress, expressing problems or recording protests.

In majority of cases of hysteria, the symptoms are **physical,** either motor, sensory or visceral. In a few cases the symptoms could be purely psychological. Hysterical symptoms can mimic any known physical illness but detailed examination would never reveal any signs of the illnesses. The commonest **sensory** symptoms are, anaesthesia, paresthesia, hypesthesia, hyperesthesia (either absence or abnormalities in sensation) blindness or deafness, either partial or complete. The commonest **motor** symptoms are paralysis of various parts of the body, fits of various types and other involuntary movements. The usual **visceral** symptoms are vomiting, belching spells, hiccoughs, coughing spells, difficulty in breathing. In many cases of hysteria, the anxiety and concern which the patient has for his symptoms or illness are inconsistent with the actual or apparent seriousness of the symptomatology. Very often, more than the patient, it is the relatives who are concerned and who need to be reassured.

Management involves removal of the hysterical symptoms with suggestion and psychological support. Least attention should be given to the patient's symptoms. Identifying the problem by talking to the patient and family members and thus improving the communication are other steps. A physical examination should always be carried out to rule out the possibility of any physical illnesses.

In our country, particularly amongst the rural population, it has been shown that most neurotic patients have physical complaints and consequently attend health centres with predominant bodily complaints. These complaints include headache, backache, aches and pains in various parts of the body, other sensory symptoms, dizziness, generalized weakness, tiredness and disturbances in sleep and appetite. These patients tend to attend health centres repeatedly and spend a lot of time and money on getting treatment - injections, tablets, x-rays and at times even surgical operations which are not really needed. They not only spend a lot of time themselves for treatment but also take away a lot of time of the health centre doctor and other health care staff. It is important to recognise and appropriately manage these patients. (Chapter IX)

Psychosomatic symptoms and diseases

Some people develop physical symptoms and illnesses because of long standing emotional problems or tensions. They generally do not exhibit their emotions and suffer silently. This can have an effect on their body and their health deteriorates. They develop various bodily symptoms and can develop known psychosomatic illnesses like peptic ulcer (stomach pain), high blood pressure, asthma (breathing trouble), and arthritis (joint pains). Psychosomatic symptoms are more common in women and older people. It is also common among people who have undergone family planning operations. You should listen to the symptoms of such patients with sympathy, and enquire about other psychosocial problems. Reassure them with kind words and make them more happy in their surroundings and they will improve. (Chapter IX)

In all types of neuroses, identifying and understanding the underlying psychosocial problems, mobilising love, support and encouragement and timely help to the patient are more beneficial than prescribing drugs.

'Sexual Neurosis' arising out of 'masturbation and/or loss of semen'.

Many youngsters consult their doctors with symptoms like weakness, inability to concentrate, poor memory, becoming sad, lack of interest, sleep disturbance etc., and request for a good tonic. On examination, doctors find them physically normal.

When the doctor asks these individuals what is bothering them, they hesitatingly tell that they are in the habit of masturbation, or they have nocturnal emission and they are losing semen. They attribute all their symptoms to this and request for some powerful medicine either to stop the act of masturbation or to restore the 'damage' done by the 'loss of semen'. There is a belief among people that masturbation is bad for health and loss of semen leads to loss of potency. After indulging in masturbation, they develop a guilt feeling and also a fear that they may become impotent. Any natural change in their health due to other psycho-social or environmental causes makes

them erroneously attribute it to masturbation. Often they do not feel like consulting the doctor and 'expose' their 'weakness', they fall prey to self-styled 'sex healers' who thrive by exploiting and perpetuating the ignorance.

Many do not know that nocturnal emission is a natural phenomenon and is harmless. Masturbation by itself does not have any deleterious effect either on the body or on the mind. Masturbation can however, cause a problem indirectly, when the individual burdened with misconceptions excessively worries over it as the cause of his symptoms (which are due to some other causes) and suffers because of the excessive worry. Masturbation can also be an expression of some other deep seated problem like excessive boredom or neurotic doubt in one's own sexual potency. Though by themselves, masturbation and loss of semen are harmless, the associated fear and guilt cause damage not only by worrying about them, but also by leaving the real psycho-social causes of the presenting symptoms unattended.

Ramesh, an adolescent boy of slightly below average academic potential appearing for 2nd PUC, comes from a family with very high and strict expectations of his parents to score high marks. He develops somatic symptoms and features of depression like weakness all over the body, fatiguability, lack of interest, forgetfulness, poor concentration. But, he does not know them to be related to his fear of the possible outcome and consequences of the forthcoming examination. Incidentally, he has been masturbating, feeling guilty about it and fearing terrible consequences. He then 'conveniently' (not consciously or deliberately) connects his symptoms and masturbation, and believes them to be related, because popular lay literature he has read or heard say so.

These cases can be provided help by the following measures. First, identify the clinical syndrome (viz: depression, anxiety neurosis) by detailed enquiry for other clinical features. Next, enquire and identify the basic psycho-social cause of the presenting symptoms. Educate, counsel and reassure the patient about the symptoms being un-related to masturbation. Next, counsel the patient and his family about the basic causal factors, namely high expectations in studies. Symptomatically, if indicated, minor tranquilisers can be used.

Psychiatric aspects of contraception

Reproduction is one of the important and basic functions of a living being. Naturally any attempt to control or stop this function can generate some amount of apprehension in an individual. Sometimes there may be some complications (both organic and psychogenic) with these methods. Thus the individual gets into a conflict between the age old beliefs and the advantages of a limited family. If a family planning method is forced on individuals without preparing them well beforehand to accept it, it can lead to problems.

It is common experience of many doctors that several individuals after undergoing family planning operations, report a wide range of symptoms starting from vague aches and pains to impotence. They may blame the doctors or the method and become chronic patients.

Sexual symptoms are the most commonly reported complaints following vasectomy. It is estimated that in our country, on an average 10% men report various degrees of sexual inadequacies like poor erection, decrease in desire and sexual frequency. The psychological symptoms reported are irritability, depression, nervousness, lack of concentration, vague aches and pains, discomfort, inability to do hard work. Similarly, a large number of women are reported to develop menstrual, sexual and psychological symptoms following tubectomy operation.

As a sequelae of **induced abortion,** it is observed that women present with symptoms of guilt, regret, depression and anxiety. Thus is general 20-30% of subjects complain of various kinds of physical, sexual and psychological symptoms after contraceptive methods. These symptoms may arise out of (i) personality, (ii) a form of social protest when decisions are taken not by the individual but by others, (iii) the family planning method becoming a very easily available reason to blame for a lot of other problems that have already been there.

With **oral pills,** it is estimated that 8 to 30% of women report psychological symptoms like nausea, giddiness, vomiting, general malaise, burning sensation, headache, insomnia, decreased sex desire etc, as a result of the effect of the pills (more pharmacological than psychosocial).

Proper education, removal of the misconcepions, moral and emotional support, good motivation, more effective and smoother methods, prompt and timely attention to any side effects, regular follow-up, encouragement and reassurance will be of help. **A good doctor-individual relationship is important to help these individuals.**

VII Childhood Mental Disorders

'A healthy child is a happy child' is a commonly heard saying. Health not only means physical well-being, but also psychological well-being. As a child grows in age, his physical and mental developments also occur.

There are two aspects of behaviour of children. Firstly they gradually, with increasing age, show increased physical and mental capacities to interact with others in the environment. This is seen as play activity, creativity, learning new tasks and questioning elders about aspects of life around them. The second part is the presence of some types of behaviours like naughtiness, telling lies, stubborness and other behaviours considered normal for short periods at different age levels. The striking aspect of childhood behaviour is the acceptance of some types of behaviour as normal at some age levels while they would be considered not normal at other age levels. This brings up the issue of **how to recognise a child with a mental health problem?**

Recognition of a child with a mental health problem

These children usually do not have any physical abnormalities. However on the basis of the following 3 parameters a distinction may be made :

(1) A child's **behaviour is not appropriate to his age**. 10 year old Ramu continues to wet his bed, it is considered a problem, or if 14 year old Shiva tells lies and doesn't go to school; but plays marbles with his friends, this is abnormal.

(2) A child's **behaviour leads to disability :** 9 year old Raju, does not sit in one place even for a short while, keeps running around, does not attend to simple activities, breaks the toys and pots. Because of this behaviour Raju does not learn anything in the class and fails repeatedly. He is a hyperactive child.

(3) A child's **behaviour is against the social expectations.** 13 year old Vishva steals a plate from the hotel, or biscuits from the shop, or money from his father's pocket, he is considered as a child with a mental health problem.

How common are childhood problems: Children with abnormal or problem behaviour are about 5-10%. Very often they are missed out because people are not aware of this as a health problem.

Why children behave abnormally? There is no single reason to explain a child's abnormal behaviour. Very often a number of reasons together disturb the child. Mental health problems in a child are caused by (1) psychological factors (2) social factors and (3) biological factors.

1. Psychological factors

Parent-child relationship : Just as protein and vitamins are necessary for a healthy physical development, so also a healthy parent-child relationship is essential for healthy mental growth. Faulty parent-child relationship can occur when parents neglect the child, or not want him at all (reject him) or overprotect him. This makes the child emotionally insecure, more dependent and lack self-confidence.

Quarrels between parents : Homes that have parents who frequently quarrel, beat or abuse one another, make the child insecure. Such a child may start hating one parent and feel that his parents do not care for him.

Broken homes : When a parent dies, separates from the family or a step-parent is brought in, we find that the child may not be able to adjust to this new situation and manifests this in the form of abnormal behaviour.

Discipline : Excessive disciplining is as bad as no disciplining at all, as both can lead to problem behaviour. Inconsistency in discipline occurs when parents differ in their attitude towards the child. Thereby the child's training suffers and he wonders whom to obey. In some instance he may learn to take advantage of one parent over the other.

Jealousy among the children : Frequently, because of partiality shown to a child, or a large age difference between the first and the second child, jealousy may occur. As a result of which, the child might behave in an abnormal manner.

2. Social factors

Poverty : Poverty is one of the important problems we face in India. This may occur due to low income, or misuse of the income, as in case of alcohol consumption by a parent. Poverty prevents the child from going to school, having nice clothes, toys etc., things appropriate to his age. It prevents him from getting sufficient to eat. Poverty forces him to take up a job even when he is only 8 or 10 years old.

Unhealthy environment : A child living in an overcrowded place with alcoholics and criminals in his environment, has a higher risk of developing abnormal behaviour.

3. Biological factors

Hereditary : When the child has a particular abnormality in his family, the chances of the abnormality occurring in him are higher. A child with a family history of epilepsy runs a higher risk of getting epilepsy.

Physical defects : A child who is blind or deaf may develop other behavioural problems too, because of the defect itself or because he is illtreated by others.

Illnesses : Certain diseases of the brain lead to behavioural problems. Encephalitis can make the child hyperactive.

Low intelligence : A child who is retarded may develop behavioural problems, because he may be unable to learn in school or even with regard to his personal and social skills.

Mental disorders in children (upto 6 years)

(1) **Dull and withdrawn** children may be brought by parents with complaints of being dull, withdrawn, less active compared to other children or in comparison to earlier behaviour. This can be due to : (i) Mental retardation (ii) physical illness or deformity (iii) Emotional problems.

Obtain details regarding milestones of development to rule out mental retardation (see section on mental retardation). Carry out a physical examination to rule out any physical illness or deformity like partial blindness, deafness, etc. Then get details regarding the parents, family and any particular psychosocial problems.

Depending on the cause, management should be planned. If the child is mentally retarded, advise training (see section on Mental Retardation). If there is any physical illness or deformity, plan appropriate intervention. If there are psychosocial problems, try to understand them and help the parents to find solutions for the same. Meanwhile child should be encouraged to get involved in activities with the help of parents and other children. In difficult cases, specialists' help should be sought.

(2) **Hyperactivity** children can be brought for over activity or inability to concentrate and learn specific skills. Over activity may become a nuisance to others. Such a child may not keep quiet even for a minute. The causes are mental retardation, minimum brain damage and emotional problems.

Obtain details regarding milestones of development, history suggesting brain damage like difficult labour and birth trauma, meningitis or encephalitis, head injury etc. Get details of any psychosocial problem as in some cases over activity may be a method of drawing attention of the elders by the child.

If the hyperactivity is severe, small doses of tranquilisers can be prescribed, i.e. 25 mg - 100 mg of chlorpromazine or 5-10 mg. of Diazepam. In addition to this child has to be engaged in doing some attractive and purposeful activity, like making dolls from

clay or wet flour, playing with wet sand, drawing or painting, cutting pictures gardening. Drugs should not be used for longer periods of more than 2 weeks continuously.

Mental disorders of children : (6 to 15 yrs)

1. **Bed wetting (Enuresis) :** Bed wetting is a disturbance of the voluntary control of the urethral sphincter. By about 3 years of age an average child learns to control himself. However there are some children in whom this control has not been adequately mastered and hence they wet their beds even after 3 years of age. Bed wetting can occur because of medical reasons (eg. genito urinary tract infection). It can also occur due to psychosocial reasons. (eg. lack of adequate training because parents are over-indulgent or careless and indifferent). It can also occur as an attention-seeking behaviour or symptom of emotional insecurity in a child.

   Any biological or medical reason if present should be treated, after a thorough physical examination and routine examination. If no medical reasons are found the following guidlines will help.

   Clarify to the parents their doubts regarding the reasons for bed wetting. Reduce the quantity of fluids after 8 PM, and give his dinner earlier. Train the child to visit the toilet before going to bed. And make sure that the child is not frightened by having to go out alone in the dark or to sleep alone in the room. Reassure the child before putting him to bed. Reward the child following dry nights. Do not scold, beat or punish the child if he/she wets the bed. Talk to the child and teach him patiently. Attend to his problems if any. Imipramine 25-50 mg at 8.00 PM can be of benefit in some cases. This should not be used for more than 4 weeks at any one time on a continuous basis.

2. **Scholastic backwardness :** This is one of the commoniest problems that teachers and parents face. A scholastically backward child is one who has difficulty in coping with the standard in school. This can occur due to (1) mental retardation (2) some physical illness because of which he is frequently absent (3) some specific problems such as difficulty in reading, or learning to write, or misidentifying letters of the alphabet eg. b for d (4) partial blindness or deafness. (5) psychological reasons such as unhealthy teacher-student relationship, shyness, a critical parental attitude, constantly forcing the child to study and comparison with other children etc. You can help these children by assessing whether the failure is due to low intelligence. Attend to the emotional problems if present and help the child to get support from parents and teachers. These children may need help of a specialist initially.

3. **Hysterical conversion :** Hysteria is a common disorder among children. It can present with headache, tremors or fits. In hysteria there is a situation that the child finds difficult to cope with and hence develops a symptom. Eg. 13 year old Rathna complained of continuous headache for one year. On interviewing the child and her parents, it was found that the child was being forced to work in a silk factory because of monetary problems at home, in spite of the fact the child wanted to continue her education. After a hard day's work she was expected to do her share of the household work. After about 6 months of this strain, Rathna developed a headache and found that her parents were much more considerate, would not force her to go for work and gave her better food. This continued and hence the patient's headache continued too.

You can help such children by (1) finding out details of the underlying problem (2) Trying to explain this to the concerned people and thereby reducing the problem. (3) Reassuring the parents. (4) Telling the parents not to give the child much attention when she is complaining (5) Talk to the child and explain the reason as to why the symptom occurs and assist her to find different ways of handling conflicts.

Other problems seen in childhood are frequent lying, stealing, running away from home, refusing to go to school, truancy and stammering. If any of these are present such children should be referred to a psychiatrist.

MENTAL RETARDATION

Vidya is a **10 year** old girl. She is short. She cannot speak clearly. She cannot pu on her clothes, or take bath herself. She does not understand much and has beer in the same class for 2 years. Other children think that Vidya is 'dull'. They do no want to play with her. They make fun of her. On talking to **Vidya's** mother we find that Vidya is different from her other children. Her development, especially mental has been rather slow. Her mother says that she behaves like a **3 years** old child. Vidya's brothers and sisters help her to finish her work. Vidya spends most of the time playing outside the house. People in Vidya's house got worried when she was unable to learn or remember simple things. So they took her to healers and temples. Even doctors gave her many medicines. Nothing has been of use, to make her like a girl of 10 years

What is Vidya's problem?

As we can see, Vidya is not like her brothers, sisters or other children of her age She is one of those children who have **low intelligence** and are called mentally retarded or dull.

What is intelligence? Let us look at our hands. We can see that all our fingers are not of the same length or even the same shape. Some are long while others short Similarly brains of different persons differ in their capacity to solve problems, to learn new things, to remember past experiences or understand new situations. All these functions of the brain, grouped together is called intelligence. **Mental retardation is a subnormal state of intelligence. It is not an illness but a condition of poor development of the brain. Children who have this condition are called dull or 'mentally retarded'.**

We find that three percent (3%) of the general population are mentally retarded. Mental retardation occurs among every caste, creed and amongst the rich as well as poor

Normally, a child of a certain physical or chronological age, should have a mental age that corresponds to his physical age. When we find that his mental age is lesser than his physical age, we consider him to be mentally retarded. Very often the parent of a mentally retarded child is able to approximately give the mental age of the child. Intelligence of a person is referred to in terms of intelligence quotient (IQ). It is calculated from mental age (MA) and chronological age (CA) as follows.

$$IQ = MA/CA \times 100$$

For example, an 8 year old child with a mental age of 4 years has an IQ of 50. A person of average intelligence has an IQ of 90-110. **Less than 70 IQ is considered as mental**

retardation. An IQ of more than 110 indicates superior intelligence. 95% of the general population are of average intelligence.

What are the degrees of mental retardation?

Mental retardation can occur in **mild, moderate** and **severe** degrees.

Mild retardation : If the mental growth of the child is more than 1/2 but less than 3/4 of what is expected at that age, we say that the child is mildly retarded.

Moderate retardation : When the mental development is more than 1/4 but less than 1/2 of what is expected we say that the child is moderately retarded.

Severe retardation : When the mental growth is less than 1/4 we say that the child is severely retarded.

How do we recognise Mental Retardation

There are two ways through which we can recognise a mentally retarded person.

(1) By talking to the mother in detail about the growth of the child.

(2) By observing the child's physical appearance and his behaviour.

Details of growth

As we see in the case of Vidya, her mother is able to tell that her daughter's mental growth has been slower than her physical one. Her milestones of development i.e. sitting, walking, talking have been delayed too. Vidya has also been failing in school. Children of Vidya's age are able to dress up, take bath, avoid dangers like fire or traffic, but Vidya being retarded is unable to do so.

★ Mental Retardation (MR) can be recognized from history of delayed developmental milestones. Following are 5 important normal milestones of development.

Holding neck erect	Sitting with support	Walking	Speaking few words or phrases
3 months	6 months	9 months - 1 year	1-1/2 years

★ **MR can be identified at different stages of growth through the following features.**

Below 5 years through history of delayed milestones.
Above 5 years through history of school failures, behaviour problems, and behaviour against society's expectations.

Physical appearance

Children with MR sometimes have certain physical features which make them easily identifiable. These characteristic features appear more in the severely retarded. Mildly/moderately retarded individuals need not have any physical abnormalities and look normal. The commonly seen physical characteristics are : small/large head, light coloured or soft hair, rough skin, slanting eyes, thick protruding tongue. **Remeber that most mentally retarded children look like other children**. One of the easily recognised condition with physical abnormalities is DOWN's SYNDROME (Mongolism). This condition is due to an extra chromosome. They have features like moonshaped face, slanting eyes and simian crease. These children are also very pleasant and friendly, the average head circumference is 51 cms. When the head is very small, the condition is called microcephaly. Very large head can be due to hydrocephalus.

Why do we need to identify mental retardation early?

Early detection of mentally retarded children is important because:

1) Early guidance to parents will result in early training for the child.

2) It can prevent further deterioration, if the mental retardation is associated with epilepsy or any other treatable medical condition.

3) Finally we can help parents accept their child's condition and thus prevent them from spending further on magical cures.

What causes mental retardation?

Mental retardation is caused by a number of factors which occur before birth, at the time of birth, or after birth. A number of these factors can be controlled and in this way prevent mental retardation.

Factors before birth

Poor nutrition in the mother, taking medicines without consulting doctor, infectious illnesses in the mother such as, measles/syphilis, drinking alcohol are causes which can be prevented. Proper health education to pregnant mothers, telling them about the irreversible nature of the condition and how they can prevent it by taking nutritious food, having check ups from time to time and having the delivery at the hospital. Children born to mothers above 35 years have a greater risk for Down's syndrome. Taking of x-rays in the first trimester can cause foetal abnormalities.

Factors at the time of birth

Complications at the time of delivery can damage the brain. For eg. delayed or prolonged labour, wrong use of forceps, excessive bleeding and the child being unable to breath immediately after birth. History of PET and APH also enhance the risk of the baby being retarded.

Factors after birth

In certain cases, the baby may have been normal, but some factors occurring later lead to mental retardation. For eg. poor nutrition in the first 2 years, illnesses such as jaundice, fever with fits, untreated epilepsy and brain fever can damage the brain cells.

In some families, there can be **more than one mentally retarded** person. In such situations hereditary factors play an important role. One of them is cousin marriages. In some parts of India, like the hilly areas, iodine deficiency causes goitre and **Cretinism**. Adequate precaution and early recognition can minimise the brain damage with adequate treatment.

Management

You have an important role to play in the prevention and management of mental retardation.

Mental retardation cannot be cured by medicines or any other method. A mentally retarded child or individual can be trained to utilise his existing mental capacity.

To help a mentally retarded child, use the following guidelines:

(1) Obtain information from the parents regarding what the child **can** and **cannot** do.

(2) Find out what the parents would like the child to be trained in.

(3) Assess the level of mental development of the child.

(4) According to the mental age decide on the target activities ranging from the easiest to the more difficult ones.

(5) Divide the target activity into sub groups (steps). For eg. If bathing is an activity, just teach the child to hold the mug, then to pour the water on himself, then to rub the soap, and finally wash it off. Teach each step at a time.

(6) Advice the parents to repeat the same activity every day for 2–3 weeks.

(7) Perform each activity with the child rather than instructing him to do it on his own.

(8) Each activity can be taught as a game.

(9) Reward the child with a sweet or praise everytime he performs the desired activity.

(10) Advise the health worker of the area to follow-up these children at least once a month.

In case where epilepsy or other medical conditions are associated, the child would need medication. For families with multiple persons with mental retardation, refer them to a specialist for genetic counselling.

In certain states (like Karnataka), aid from the Government is available for severely retarded individuals. You can help the family to obtain this by arranging certification and other procedures.

Referral

Mentally retarded child need not be referred to a specialist except :

(1) Suspect a physical condition causing mental retardation for diagnosis with investigation.

(2) if there are multiple handicaps,

(3) if family reaction is not healthy and the family needs detailed counselling and training and

(4) genetic counselling.

SIMPLE GUIDELINES FOR CHOOSING ACTIVITIES FOR A RETARDED CHILD

Age levels	Normal development	Training
0 - 2 yrs	★ Recognizing familiar people ★ Walking ★ Talking in short sentences ★ Does not drool ★ Can follow simple instructions ★ Can drink from a glass unassisted ★ Can differentiate between edible substances.	I. **Provide sensory stimulation.** ★ Different colors ★ Different smells ★ Different sounds ★ Different touch II. **If weakness of limbs is present provide** ★ Massage to the limbs ★ Use wooden cart for walking.
2 - 4 yrs	★ Recognizing & identifying simple objects. ★ Can chew his food ★ Can be toilet trained ★ Can help with simple household activities. ★ Can avoid simple dangers eg. fire.	★ Follow general guidelines of training and train in different activities.
4 - 7 yrs	★ Can bathe & dress himself ★ Starts playing with other children ★ Can write a few words. ★ Can do simple calculations.	- same -

VIII Epilepsy

Epilepsy is a disorder of the nervous system in which altered level of consciousness occurs whenever there is disturbance in the well ordered functioning of the cells within the brain due to electrical disturbances. The most characteristic aspects of epilepsy are the repetitiveness and recovery after an attack. It can start at any age. In majority of cases, it starts in childhood or adolescence. The common causes of epilepsy, in developing countries like India are: (i) birth injury (ii) difficult labour (iii) brain infections and (iv) head injury. However, in many cases it occurs without any clearly identifiable cause.

It is estimated that about 8 to 10 persons in 1000 population have this problem at any one time.

Type of epilepsy : There are 3 common types of epilepsy :

1. Grandmal or Generalised epilepsy
2. Focal epilepsy (including temporal lobe epilepsy)
3. Focal epilepsy becoming generalised.

Grandmal epilepsy

Recognition of epilepsy : The most important aspect of diagnosis is a very **good and clear history.** It is not always possible for you to have an opportunity to see an actual fit in a given patient. In view of this, you have to talk to the family members of the patient who have seen one or more fits. It is not adequate to depend on the information given by the patient as patients do not have memory for details of the fit. On talking to a relative, the history provided would include a description, more or less, as follows:

"The attack or the fit occurs suddenly. The attack can occur at home, school or place of work. He falls down and loses his awareness of surroundings (unconsciousness). This is associated with a loud cry. The face is noted to be red and the eye balls are rolled up. This is followed by a short period of few seconds when the whole body becomes stiff. Soon he starts moving his hands, legs and rest of the body in a rhythmic manner (jerky movements). At this stage frothing of the mouth is also noted. At times he wets his clothes with urine. He does not respond to what others are saying all this time. Gradually the jerky movements become less and the patient becomes completely silent and goes off to sleep. On waking up he is not aware of what happened to him during the attack. He has bodyaches, fatigue and prefers to take rest. Sometimes, after a fit the patient remains confused and behaves abnormally for a short period."

In some patients, before the fits there are some clear changes like becoming dull, irritable, complaining of headache, smacking of lips and staring at blank space. These changes suggest that patient is likely to get a fit and if a pattern is known then he can prevent harm during the fit, by reaching a safe place on experiencing these symptoms.

Focal epilepsy: The convulsions (jerky movements) start in one part of the body like the hand or leg, or a side of the face and are either confined to that part only or are followed by a generalised epilepsy.

Temporal lobe epilepsy (TLE) : Unlike in grandmal epilepsy, loss of consciousness is not the striking feature. Patient behaves in an abnormal manner for a few minutes in which he appears to be angry, apprehensive and carries out repetitive purposeless activities which he has no memory. In between the attacks he is completely free of any disturbance. He may also experience hearing of voices, see visions or smell foul odours. It is of often mistaken for psychosis but can be recognised as TLE by its short duration, normalcy in between the attacks and repetitive nature of the behaviour. It is because of the behaviour changes that predominate the presentation, that it is also known as **psychomotor epilepsy.**

It is important to talk to a relative who has seen the fit to arrive at a diagnosis. Following questions help in arriving at a diagnosis :

1. What is the duration of fits?
2. What is the frequency?
3. How it starts?
4. Description of the attack step by step.

Differentiation from hysterical fits : You will be seeing other patients having attacks of fainting or anxiety which can be mistaken for epilepsy. These fits occur due to emotional problems. In these patients the characteristics of the fits are different.

	Epilepsy	**Hysteria**
1) History of fall and injury	Present	Absent
2) Fits when alone/during sleep	Yes	No
3) Every fit same as the other	Same	Different
4) Movement of the limbs	Regular	Irregular
5) Tongue bite	Yes	No
6) Incontinuance of urine and faces	Present	No
7) Inducing an attack by strong suggestion	Not possible	Possible
8) During an attack-pupils and plantar reflex	Dilated pupils; upgoing plantars.	Normal

Persons with hysteria are also emotionally ill. They need emotional support and understanding (see section on neurosis and counselling, Chapters VI and IX A).

Diagnosis of epilepsy is made by a reliable and good history.

There are no laboratory tests to arrive at a diagnosis. X-ray skull, EEG etc., can help to find epileptic foci in some cases only. These investigations are needed in cases of focal fits, late onset (above 20 years age) epilepsy, and epilepsy with neurological findings on physical examination.

Presentation of patients : It is possible that you are not seeing these patients at present. This is for two reasons - (i) people do not think of it as a health problem and (ii) your pharmacy may not contain the needed medicines. Once you start educating the public and demonstrate the ability to treat, they will start coming to you for the control of 'fits'. In addition, you should think of underlying epilepsy when you see patients of i) Repeated burns and injuries, ii) children with poor mental development - in some children with mental retardation (see Chapter VII) there is associated epilepsy, iii) abnormal behaviour of few minutes only, either with or following fits, iv) poor school performance.

In addition you may hear of a person who is taking treatment from traditional healers for being 'possessed by evil spirits'. These persons can be having epilepsy.

Help in acute attack - First Aid

Sometimes you can come across a patient during a fits. It is best to make the person. comfortable in a safe and open place. No crowds should gather around the person. Sharp and dangerous objects, if they are near the patient should be removed. Loosening his clothes is another way of making the person comfortable. Put a rolled cloth between the front teeth to prevent tongue bite, and turn the face to one side which will bring out the secretion from the mouth. Do not pour water or put anything else into the mouth during the fits. Similarly do not try to hold arms or legs when they are showing jerky movements. The fits will usually last for 2 to 5 minutes and then the person will go to sleep. He may become confused for about 30 minutes. Both these conditions will improve by themselves in a short time, usually within one hour.

Drug treatment

The following regime is to be followed :

Only one attack, wait, ask the patient to report to you if he gets the second attack.
At least two attacks in 6 months, start treatment.

Start with one drug like — Phenobarbitone which is inexpensive and effective. Start with a small dose depending on the age. For example:

3 years	— 15 mg single bed time dose.
3-10 years	— 30 mg single bed time dose.
Above 10 years	— 60 mg single bed time dose.

Give the **following instructions** clearly, taking care that they are understood properly by patient and family members. (i) Take tablet at bed time, **regularly, not missing even a single dose,** (ii) patient may feel drowsy in the beginning. This should not lead to any change in drugs dosage on his own, (iii) **missing dose can result in a fit.** Keep stock of tablets for at least two weeks always, (iv) keep them in a safe plastic container to avoid misuse or accidental use by others especially children, (v) keep a small book and record all the 'fits', (vi) Regular follow-up is essential for adjustment of doses and assessment of any side effects, (vii) visit the doctor in the beginning once a fortnight, later once a month, (viii) till fits are fully under control do not work near fire, water, moving wheels, do not climb trees and do not drive vehicles, (ix) there are no food restrictions as part of treatment, (x) continue all routine work (going to school, work etc.)

Drugs have to be taken for a minimum period of 3-5 years after the last fit.

Follow-up

If the patient reports that he had a fit, during the follow-up visit, while on treatment,

1. Check whether he is taking tablets in the required dosage,
2. Look for precipitating factor like fever, alcohol intake, sleepless nights, missing a meal, and advise accordingly.
3. Rule out hysterical attack **(remember some individuals can have a combination of both genuine and hysterical fits.)**

When you have clarified that the patient is really getting epileptic attack in spite of regular medication step up the dose by 30mg. You can go upto 180 mg a day in an adult. If attacks are not controlled add **Diphenyl Hydanotin** 100mg/day. Increase it to 300mg if necessary, in adults. Another drug that can be used in epilepsy is carbamazepine. It is best to discuss or get an opinion of a specialist prior to using it.

When the patient is fit free for 3 to 5 years continuously, then gradually taper the dose and stop the medication over 6 months period. In case of relapse drugs are restarted and continued for another 3 to 5 years. It is not advisable to give more than 4 weeks supply of drugs at any one time.

Refer the patient to a specialist if fits are not controlled in spite of the above regime for 3-6 months and patient develops some neurological findings like paresis, ataxia, nystagmus, confusion or forgetfulness.

Long term complications with drug : There are no major side effects, no serious complications with long-term use of Phenobarbitone. With Diphenyl Hydanotin some can develop hypertrophy of gums, excessive hair growth after long term medication. A few develop ataxia and nystagmus, which disappear after reducing or stopping the drug.

Status epilepticus : Sometimes a patient who is getting attacks continuously without regaining consciousness in between the fits can be brought to you. **It is medical emergency.** Give Diazepam 5 to 10mg i.v. slowly. Following the Inj. Diazepam i.v, patient will also have to be given phenobarbitone intramuscularly. (Inj. Phenobarbitone 200 mg im). In most cases, these steps will stop the attacks. In case the attacks are not stopped, patient should be referred to a specialist. It is advisable to hospitalise a patient of status epilepticus and keep him under close observation. Adequate attention should be given to his nursing especially when he is unconscious. Once the fits are controlled, the parenteral antiepileptics will have to be replaced by regular oral antiepileptic medications.

Febrile convulsion : At times children of age group 6 months to 3 years are brought with a history of fever and fits. If the child has status epilepticus, has family history of epilepsy and frequent attacks of fits with mild fever, start treatment. Otherwise do not put the child on treatment. Reassure the parents. Advise them to bring down future episodes of fever by antipyretics, tepid sponging and report to you. If the child gets an attack without fever, start treatment.

Individual and community consequences : Epilepsy can affect persons of all ages. The fits of an individual can make him look different to others and this can create difficulties and inferiority feelings. In addition, the general beliefs in the community about the disease being infectious or heriditary, can create problems at work and marriage. During the fit he can get hurt and this may result in disability. If the fit occurs in the middle of the road, or near water or fire, or while working near moving machines, or heights it can be fatal. **The importance of controlling fits lies in decreasing harm to the individual, preventing social stigma, improving his social functioning, and minimising brain damage.**

Helping families to live with epilepsy : When a person is affected by epilepsy, his parents and family members become panicky and they search for a reason for the illness. Sometimes parents get too anxious and overprotect to the extent the child is made an invalid. Here arises the need for guidance and counselling to the parents

in the management and rehabilitation of the epileptic patient. In the beginning parents of the patient will not be willing to accept the treatment. At this stage talk to them not once or twice but many times and try to make them realize that this is an illness and with treatment patient will get better, stop having the fits, can work properly that the disease is not infectious or contagious. In all cases, you can reply in an optimistic way. These persons can lead the life of a normal person after getting better with the control of fits by regular medication.

IX Treatment of Mental Disorders

In an earlier section, it was noted that mental illnesses are caused by a variety of factors. Hereditary factors, changes in the brain chemistry, unhappy childhood experiences, conflict in the family, various real life stresses and strains, social problems and many other factors complexly interact to produce the symptoms of mental illness and the various clearly defined syndromes.

It is often widely thought that mental illnesses cannot be treated at all and no specific methods exist for the management of mentally ill persons. People are reminded of mental hospitals where mentally ill persons stay for very long periods of time, sometimes for life. All types of mental illnesses are equated with chronic psychoses. But during past few decades, major advances have taken place in the understanding and management of different types of mental illnesses. These significant developments have contributed to more satisfactory and effective treatment for many of the mental illnesses.

There are mainly two basic approaches to the management of mental illnesses: The psychological or psychotherapeutic and the organic/biological or pharmacological. Both these methods may be used either separately or jointly. In each patient a careful understanding of the factors involved in the illness will help the doctor decide the specific individual approach required for satisfactory treatment.

The following section covers the different treatment approaches.

A. Psychological management
B. Drug management
C. Rehabilitation
D. Phychiatric emergencies and hospitalisation
E. Legal aspects of psychiatric care

A. PSYCHOLOGICAL MANAGEMENT (PSYCHOTHERAPY)

In your medical practice you have come across patients who related their life problems to you. If you look back, you would realise that very often patients who come with vague bodily complaints have the tendency to talk about their various concerns and worries to their doctor. Most doctors are generally not very comfortable in handling patients 'real-life stresses'. We have difficulty in taking the role of a counseller or psychotherapist. Many doctors, even fail to recognise the unavoidable psychotherapeutic aspect of their role as a doctor. This is largely because, undergraduate and post-graduate medical training does not prepare the future doctor.

or specialist to recognise and care for the emotional needs of his patients.

Psychotherapy essentially attempts to restore the emotional equilibrium of a person in distress by psychological means. It involves very simple measures like **listening** to a person in distress about his difficulties, **understanding** the nature of his problems and talking to him. An authority in this field has said 'Psychotherapy to a large degree is nothing but a systematic conscious application of methods by which we influence our fellow men in our daily life. The most important difference is that intuitive knowledge is replaced by the well established general principles of psychodynamics'. There are different major schools of psychotherapy which have developed specific techniques for specific types of mental illnesses with specific goals. While the various psychotherapeutic techniques and methods are important for a specialist in the field of mental health, all doctors can become familiar with the basic principles involved in counselling and psychotherapy.

The type of psychotherapy useful in general medical practice is the **'brief supportive psychotherapy'.** The fundamental prerequisite for a successful therapy is a **relationship** between the doctor and patient of trust and confidence. The doctor must always be conscious of his being a therapeutic instrument capable of making changes in his patient. He should give ample chance for the patient to ventilate his problem and unburden himself of all his anxieties, worries and complaints. In general medical practice, though the drugs play an important role, counselling the patients about various diet and other preventive regimes is an established practice. There, the nature of counselling is obviously one of telling the patient precisely what to do and what not to do. But with psychiatric patients, the nature of counselling is considerably different, because:

(i) Though the medicines have a definite role in few psychiatric conditions like psychoses, for the large majority of patients and their psychiatric conditions the cause will be related to psychosocial situations which vary uniquely with each individual. Therefore, generalised formulation of simple and precise do's and don'ts is not possible.

(ii) In general medical practice, an individual suffering from, say a fracture, is assumed to have an adequate and well functioning mental apparatus which has to carry out the doctors advise. In psychiatric patients, the mental apparatus which has to carry out the doctor's instructions/advice is disturbed: like lack of will to live or to struggle or to face reality.

(iii) Also, most psychiatric patients will have been unable to adequately perceive and understand what the real cause of their suffering is, and to go about solving

it. Most often patients will not be in a ready frame of mind to understand it even if told what the doctor thinks of it. In such instances, it would become necessary for the doctor to proceed in simpler steps by gradually preparing the patient at each stage to understand the next step.

THERE ARE A FEW POINTS WHICH THE DOCTOR SHOULD REMEMBER ALWAYS

Though **reassurance** is a very useful too, and has a definite role in counselling, most often it does not work, because, what is really important in reassurance is: what and what not to reassure, when to reassure, and how to reassure.

What not to reassure? About what the doctor has no control.

i) The **course of the illness** that is not known, or not predictable namely, if the patient has an anxiety state due to various factors related to difficult interpersonal problems in the family, neither the patient nor the doctor has any real or direct control over what might happen.

ii) **Efficacy of drugs,** especially when the problems are psychosocial. Eg. in the above, though the anxiolytics may reduce the anxiety temporarily now and then, the family interpersonal problems may continuously keep the patient's anxiety high. .

iii) **Philosophical statements/consolations.** Almost all patients will have already known them and will usually have used themselves for self-consolation. Their relatives and friends will usually have also told similarly.

What to reassure? About what the doctor and patient have control.

i) Doctor's best and sincere efforts, availability, concern and help.

ii) Patient's ability to get over the difficulties. Every patient's life history will contain instances of some successful struggle or other however modest. These instances can be fed back to the patient to boost up his self confidence and morale.

iii) When the doctor is certain, in any given case, what and what not to reassure.

iv) After the patient has unburdened all his problems (when the patient has not yet completed saying all he wants to say, reassurance is useless because he is not yet ready to listen).

How to reassure? Method to convey the message of reassurance.

This has to be learnt by practice and experience. Most often, doctor is the only person the patient can possibly talk to about his problems (the doctor is generally believed by patients to be the only person who will listen to their difficulties). If this need is satisfied with sympathy, patience, and tolerance, more than half the treatment can be considered over.

Effective counselling has three stages or phases:

i) **Identifying the problem.** Symptoms are not problems, they are only manifestations of some other problem.

ii) **Feeding back to the patient** about the relationship between his problem and his symptoms. Enquiring further about the problem.

iii) **Helping to deal with the problem.**

Identifying the problem

First clue to the problem is related to the stress before the onset of symptoms. But generally patients do not remember that stress, but will only remember the symptoms. Therefore, first elicit the date (or period) of onset of the symptoms to as much a degree of accuracy as possible. Then, separately enquire about patient's life history, important events and their dates.

In your own mind, relate possible immediate relationship between any event and the onset of symptoms. Once a possible stress event is elicited, make further enquiries to confirm it. Eg. if the headache had started during summer 2 years previously, and if the doctor finds during his enquiries that the patient conducted his daughter's marriage 2 years ago, then enquiries along the following line will confirm the presence or absence of the stress factor: "When you conducted your daughter's marriage, did you have headache at that time? How many days/weeks before marriage, or how many days/weeks after that marriage did your headache start"?

Feeding back to the patient

Feeding back to the patient the symptom-stress relationship is the next step. This feed back in the form of questions are better than statements viz: "It is important that your headache started the day after your daughter's marriage", or " have you observed how your headache started the day after your daughter's wedding? and have you thought about it"? Many times, patients deny such a relationship when you mention it to them. Do not worry, or feel hurt that an important discovery of yours is not

accepted. Such denial only means that the patient is not yet ready to perceive and understand the implications of such a relationship.

However, continue your further enquiry about the 'identified stress' which can eventually lead you and the patient to the underlying problem. Eg. in the above example of the daughter's marriage. ''How was the marriage arranged? How did you manage the finance? Was everybody happy with the alliance? Did the marriage go on successfully''?

Helping the patient to deal with his problem

Enquire from patient what steps he has already taken to deal with it, and what the outcome was. Enquire from patient what alternative steps he has considered. What the advantages and disadvantages of those alternatives are. If appropriate, suggest alternatives that you consider appropriate. Reinforce patient's inherent abilities to cope with problems, to boost his confidence and morale.

Family problems: Frequently, the doctor during his management of a psychiatric patient will come to know that some family problems are operative in a given case. The principles of counselling outlined above should be used, but the following points must be borne in mind. **Avoid** becoming a messenger. If the patient complains to you about the wife, then do not see the wife separately. She may complain to you about the patient or her mother-in-law. This approach will in no way solve the problem. **Preferably,** see the concerned family members together. **Avoid** taking sides. Maintain **strict,** yet sympathetic neutrality. **Also, avoid** becoming a judge and passing judgements like wrong or right. The aim of counselling the family will be to make all the concerned family members understand the relationship between the nature of problem, its stress and the manifest symptoms, and to help the family members make joint efforts to get over the problem.

In helping individuals with psychological methods of treatment, it is important to remember that it takes time to see results. It is best to plan to see the patient and his family members on a regular basis for a few weeks.

If at any time, counselling the patient or family seems difficult or you do not feel comfortable, refer to a psychiatrist.

Refer patients to a specialist when you find that (i) it is not possible to identify stresses, or ther are too many stresses, (ii) the support from the family members is difficult to obtain, (iii) the complaints have been present for many years, (iv) there are associated significant physical illnesses, and (v) your efforts are not providing relief even after seeing the patient for 8-12 weeks.

B. DRUG MANAGEMENT

The history of drug treatment for mentally ill persons is only of about thirty years. Chlorpromazine, the pharmacological agent for the treatment of severe types of mental illnesses was the first drug to be discovered for use in psychiatric practice, in 1952. This discovery revolutionized the treatment for chronic and severe mental illnesses and facilitated the discharge of large number of mentally ill persons from the custodial mental hospitals in Europe and America. Subsequent to the discovery and large scale use of chlorpromazine, the late fifties and the sixties saw the discovery of a series of new pharmacological agents. Many of them are presently in use. The experience of last two decades has clearly demonstrated their usefulness and their relative safety. The most commonly used drugs fall into three major categories: 1) Antianxiety drugs - Anxiolytics or Minor Tranquilizers 2) Antidepressants and 3) Antipsychotics - Major Tranquilizers. These drugs may sometimes be used in combinations too. This section deals with the various pharmacological agents, their strengths, dosage ranges, side effects and management of side effects.

1. Anxiloytics ('Minor Tranquilizers')

Anxiolytics are effective for symptomatic relief of neurotic conditons wherever symptoms of anxiety are present; like sweating, tremors, palpitations; they also facilitate sleep. Their effectiveness as sole curative agents is however very restricted to those conditions where the anxiety symptoms are of a) very recent origin, b) the patient has in the past shown ability to cope adequately with stress, c) there are no severe and prolonged interpersonal/familial problems.

In all other cases the role of anxiolytics is limited, and the management **must** necessarily include psychotherapy and family counselling. In such cases, if symptoms of anxiety are severe, anxiolytics can be used **only** as adjuncts to other modes of managements.

Pharmacological name	Tablet strength	Some (proprietory) trade names	Daily dose
1. Diazepam	5 mg 2 mg	Diazecalm Calmpose Calm-U Paxum Calmod	5 mg O.D. TID
2. Lorazepam	1 mg 2 mg	Larpose	1 mg O.D., B.D., or T.D.S.
3. Chlordiazepoxide	10 mg 25 mg	Librium Equibrom	10 mg B.D. or T.D.S

Usually more than 15 mg per day of diazepam should not be given as it can cause drowsiness, lethargy and ataxia.

Intravenous diazepam is very effective in cases of status epilepticus. The injection must be given **slowly.**

Hypnotics should be used **sparingly.** They facilitate sleep in conjunction with antidepressants in cases of severe insomnia. The word 'sparingly' is deliberately emphasised because (a) prescription merely of an hypnotic to an insomnic person will do nothing to his problems which are causing him insomnia and there is danger of the individual **learning** the habit of taking hypnotics instead of dealing with the problems. If this happens we will be contributing to the individual's escape from his healthy and legitimate responsibilities. (b) In majority of instances, insomnia will automatically set itself right either when the underlying problem is adequately dealt with or when his anxiety or depression is treated.

Pharmacological name of the hypnotic is **Nitrazepam,** available as Hypnotex, Nitravet, Sedomon, etc., in 5 mg and 10 mg strengths. It is administered only at bed time. Rarely it can cause 'hang-over' like symptoms.

Concomitant use of alcohol and hypnotics will cause excessive drowsiness and should be avoided.

II. Antipsychotics ('Major Tranquilizers')

Antipsychotics are effective in the treatment of psychoses like schizophrenia and mania. It is also useful in those cases of depression where additional psychotic features of hallucinations and delusions are also present, alcoholic psychoses, and in organic and epileptic psychoses.

Pharmacological names	Strength	Some trade names	Equipment dose	Daily dose
Chlorpromazine	50 mg 100 mg 200 mg	Largactil Tranchlor Promacid	100 mg	100-300 mg
Trifluoperazine	50 mg 10 mg	Trinicalm Eskazine Trankozine Mephazine T.F.P.	5 mg	5-15 mg
Thioridazine	25 mg 50 mg 100 mg	Melleril	100 mg	100-400 mg
Fluphenazine Deconate (this is a depot-phenothiazine-parenteral)	25 mg/ml	Anatensol - Decanoate	—	25 mg IM once in 2 - 4 weeks
Haloperidol	1.5 mg 5 mg 10 mg	Serenace Depidol Haldol	1.5 mg	3 - 15 mg

Note: The maximum therapeutic doses mentioned above should not be exceeded in the out-patient setting. In case of Depot phenothiazine : (a) it is used generally as a maintenance medication for **schizophrenic psychoses - chronic type,** (b) the dose is adjusted by altering the interval between injections from 2 weeks to 4 weeks and also by altering the dose between 0.5 ml and 1 ml.

The different antipsychotics are equally effective when used in equivalent dosages. it is best to become familiar with one antipsychotic (Chlorpromazine) and use it as first level drug.

These antipsychotic drugs have differing degrees of **sedative effects,** and this can be made use of to meet special clinical requirements like: (a) severe insomnia is a

predominant problem and (b) the patient has to attend work during day time. The sedative effect of the drugs is mentioned in decreasing order:

- Chlorpromazine — Most sedation
- Thioridazine
- Trifluoperazine
- Haloperidol — Least sedation

SIDE EFFECTS

The following are the side effects of the antipsychotic drugs:

(i) **Minor and transient:** They usually disappear spontaneously after 2 - 3 days of treatment. These are dryness of mouth, blurring of vision and drowsiness.

(ii) **Extrapyramidal side effects**

(a) **Acute dystonic reaction:** Sudden muscular contraction, most often in neck, tongue, and pharynx; presenting as occulogyric crisis, laryngeal spasm or as protrusion of tongue against clenched teeth. One of the commonly used drugs in general practice, Triflupromazine (Siquil) frequently causes this reaction. Acute dystonic reaction can be quickly relieved by 50 mg of intra muscular Promethazine (phenergan).

Drug induced parkinsonism: The features are : excessive salivation, tremors, rigidity, mask-like face.

Akathisia : It is a condition of motor-restlessness, often accompanied by mental-restlessness, namely, the patient cannot sit or stand at one place quietly for more than a few seconds, and he is distressed. Though this picture may be seen as a part of agitated depression, there will be history of phenothiazine medication in the last 24 or 48 hours in case of akathisia.

All the three above conditions can be treated with antiparkinsonian drugs. If the patient already happens to be on antiparkinsonian drug, the dose will have to be increased. Antiparkinsonian drugs should be continued till these extrapyramidal symptoms disappear. Thioridazine (Melleril) is least known to cause these extrapyramidal symptoms.

(b) **Tardive dyskinesia :** The clinical feature is one of Buccooro-facio-lingual movements, almost continuously seen in wakeful state. There can be classical 'fly-catching' movements of the tongue, and grinding of teeth. This usually follows after 5 to 6 years. This most **troublesome** iatrogenic condition is difficult to treat. Refer to a psychiatrist.

(c) **Jaundice :** Commonly seen with chlorpromazine. Stop drugs and immediatel refer to a psychiatrist.

(d) **Postural hypotension :** If this is severe, the patient should be hospitalise and the drug stopped. If necessary noradrenaline or Isoprenaline drip started **Adrenaline is contra-indicated.** Earliest symptom is giddiness on standing If so, check B.P., both standing and lying. This problem is commonest with Chlorpromazine.

(e) **Skin sensitivity** and rarely **bone marrow depression** can take place. When these occur drugs should be stopped and patient should be referred to a specialist without delay.

Thioridazone has high anti-cholinergic side effects, and therefore should be used with caution when prescribing to elderly patients.

III. Antiparkinsonian agents

This group of drugs are effective against major tranquilizer induced extrapyramidal side effects. They should not be routinely used.

Pharmacological names	Strength	Some trade names	Daily dose
Trihexyphenidyl	2 mg	Pacitane Parkin Placidyl Hexinal	2 to 6 mg
Procyclidine HCl.	5 mg	Kemadrine	5 to 15 mg

IV. Antidepressant drugs (tricyclic compounds)

These drugs are effective against depression of any cause.

Pharmacological names	Strength	Some trade names	Daily dose
Imipramine HCl	25 mg 75 mg	Depsonil Impranil Antidep Restamine	75-150 mg

Trimipramine	25 mg	Surmontil	75-150 mg
Nortryptaline	25 mg	Sensival	75-150 mg
Amitryptaline	25 mg	Sarotena	75-150 mg
	50 mg	Tryptanol	
	75 mg	Amiline	
Doxepin HCl	25 mg	Doxetar	75-150 mg
	75 mg	Spectra	
		Sinepin	

Note: A higher or single night dose is preferable, and equally effective when the patient can tolerate.

The therapeutic benefit becomes obvious on an average about 10-14 days after starting of treatment. Therefore, it is essential to advise the patient to take the drug for a minimum period of at least 3 weeks before considering any change.

Imipramine causes least sedation. The following are the common side effects : Dryness of mouth, blurring of vision, constipation and rarely, retention of urine and paralytic ileus.

It is essential to advise the patients about these possible transient side effects so that they are prepared if they experience them and do not stop the medication.

Antidepressants are to be used with extreme caution and in consultation with the psychiatrist in patients with **glaucoma, recent myocardial ischaemia and** enlarged prostage.

V. Prophylactic Lithium

Lithium carbonate is effective in treating cases of mania, and it is widely used in preventing recurrent manic depressive psychoses. The use of the drug is best left to the discretion of a psychiatrist, though the GP can effectively provide the maintenance care.

The commonly used dose is 900-1200 mg per day in three divided doses. Because the therapeutic and toxic serum levels are closer, and because the serum lithium level tends to build up cumulatively, **it is essential** to regularly and periodically monitor the required dose by doing **serum lithium estimations.** The therapeutic effective serum lithium level is 0.6 to 1.4 mEq/1 (or milli mols/1). Beyond 2.0 mEq/1 toxic effects manifest in the form of abdominal discomforts, nausea, vomiting, diarrhoea, tremors of hand, drowsiness. If they occur, the drugs must be immediately stopped and the patient referred to a psychiatrist.

DRUG INTERACTION

Patients with psychiatric problems may need to take other drugs for other health problems. The following are some of the guidelines about drug interactions. However, if there is difficulty in regard to management of associated physical problem, it is appropriate to take the help of the psychiatrist.

Drug group	Interaction	Effect
Tricyclicanti-depressants.	Adrenaline & noradrenaline,	Hypertension depressant effect on CNS
	Alcohol	
	Antihypertensive agents	Antagonism to antihypertensive effect
Barbiturates	Alcohol, anaesthetics and antihistamines	Depressant effect on CNS
Barbiturates	Anticoagulants	Antagonism of anticoagulant effect. **In case of phenytoin** increased toxicity of phenytoin.
Barbiturates	Griseofuluvin	Reduced antifungal activity
Barbiturates	Phenothiazines	Depressant effect on CNS
	Tranquilizers	
	Buterophenones	
Phenothiazines	Anaesthetics, alcohol, Barbiturates	Depressant effect on CNS
Phenothiazines	Antihypertensive agents	Hypotensive effect
		Methyl Dopa may cause central excitation
Phenothiazines	Atropine like drugs and antihistamines	Decreased anticholenergic activity
Hypnotics	Alcohol	Increased depressant effect on CNS
	Anaesthetics	
	Antihistamines	
	Phenothiazines	
	Minor tranquilizers	

In addition, antacids when taken together delay absorption of the phenothiazines. Both antidepressants and chlorpromazine are liable to potentiate epileptic fits in known epileptics. All the commonly used antihypertensive drugs can cause depression, particularly reserpine containing drugs. Oral contraceptives are known to cause depressive symptomatology in some women. Alcohol when taken with most drugs described in this chapter enhances the depressant on CNS. In view of this, a person on psychiatric drugs should be advised to avoid taking alcohol.

C. REHABILITATION

The management of mentally ill persons can be considered complete and satisfactory, only when the patient is helped to successfully readjust to his family, occupation and community. So, in addition to psychological and pharmacological management, certain steps will have to be taken to help the patient to attain competence in his personal, social and occupational activities. These approaches are often referred to as sociotherapy and rehabilitation. It may involve attempts to modify patient's life situations, working with patients family members and other institutions in the community.

The proverb that 'an idle mind is the devil's workshop' emphasizes the importance of activity in our day-to-day life. Each and every individual is engaged in different kinds of activities, depending upon his or her socio-economic background and cultural norms of the community.

Activity may be physical, mental, social, recreational or job oriented. For example: physical activities like doing some work engaging in exercise and carrying out daily routine. Mental activities like making plans and taking decision for the future, controlling behaviour, thinking and reasoning. Social activities like talking to friends, relatives, attending religious functions, visiting religious places and taking part in group activities. Job oriented activities like office work, agriculture and other manual work. Recreational activities like engaging in singing, going to a picnic, cinema, taking part in games. Most of these activities are part and parcel of day-to-day living of an individual. These activities generally go on without much effort on the part of the individual.

In the case of mentally ill persons due to various reasons, these activities are disturbed or hampered to a varying extent. The patient can be disabled to do the physical activities, mentally he may not be able to take decisions and become incapable of proper thinking and reasoning. His social and recreational activities are very much affected and he can exhibit socially undesirable behaviour. Thus most of the time, he becomes more dependent on the family and thus a burden on the family members and on the community.

It is an important task of medical team and other care giving persons to understand

the importance of helping the patient to **re-establish or regain his interest to do useful activity** and thereby modifying his behaviour from useless to useful activity, non-productive to productive activity, destructive to constructive activity and asocial to social activity. These activities help the patient to become a useful member of the family and society, thus rehabilitating him to lead an independent life to the best extent.

The word **rehabilitation means re-building of the activities like physical, mental and social,** which prepare patients to take their place in the community to the fullest extent compared to the level of their functioning before the onset of the illness, and become an asset rather than a liability to themselves and to their families. Proper supervision, constant reinforcement and encouragement, are very essential in the initial stages. Persons involved in caring for such patients need a lot of tolerance, self-awareness and some amount of devotion to this type of work.

Family and neighbours need to understand the patient's potentialities and capabilities before involving the patients for any type of activity. Interest can not be forced but interest can be instilled. Choices have to be given to the patients in selection of the activity or task. Patient needs to be respected as an individual. Continuous support and encouragement to the patients is very essential to increase their morale and esteem. Gradually, when the patients develop or acquire the skills or art of doing the work or activity assigned, they should be allowed to do their work independently. In the long run efforts need to be made to shift the patients for alternative work in private and public sectors like industries and other vocations which will be of great use to the patients to lead independent lives in the society.

The goal of any treatment plan should be rehabilitation and re-integration of the patients to active community life. For successful rehabilitation, cooperation and collaboration of health care personnel, patients and their family members, opinion leaders and various agencies are indispensable.

D. PSYCHIATRIC EMERGENICES AND HOSPITALISATION

Psychiatric emergencies are any psychiatric conditions or circumstances of a patient which call for immediate action. Here, the decision as to what is to be done to the patient, has to be taken. A psychiatric condition will present as an emergency, usually due to one or more of the following reasons : i) patient may be a source of danger to himself or others because of his mental state, ii) patient's relatives may be extremely anxious and worried regarding the patient's condition, iii) patient may create disturbance in the community to an intolerable or unmanageable degree and iv) patient may be in extreme and unbearable distress.

Approach to a psychiatric emergency

History taking, however brief it may be, is very essential. Inquiry should be made regarding the possibility of any probable precipitating factors. A thorough examination of the patient including measurement of blood pressure should be done. Examination of the patient should preferably be in private except in cases of excited patients, in order to give the patient a chance to talk about any distressing issues. Avoiding restraints as far as possible will be useful. Do not deny the reality of the patient's experiences. You must try to express your respect for the patient and by direct verbal reassurances, inform the patient of your interest in the patient's welfare. You should reveal your identity and try to avoid pretending to be otherwise. The following are psychiatric situations that should be considered as emergencies:

1. Suicidal attempt
2. Excitement
3. Stupor
4. Dystonic reaction
5. Lithium toxicity
6. Hysteria

1. Suicidal threats, gestures, attempts and risks : No suicidal threat, gesture, or attempt should be taken lightly. Do not take the assurances of the patient for granted. There are no definite and fixed criteria to differentiate between genuine and spurious attempts. An over dosage of drugs or intake of poisonous substance is seldom accidental and almost always suicidal. Frank admission of suicidal intent by the patient can be relied upon, but never his denials. It is desirable (and not harmful) to discuss openly about the risk of suicide/suicidal attempt, with the patient and the relatives. The following suicidal situations, namely a) suicidal attempts with farewell or other note, b) many suicidal attempts, c) suicidal attempts with more lethal methods, when alone and pre-planning had gone into the execution of the attempt, d) past history of suicidal ideas and e) elderly patients should be considered as real suicidal attempts.

Management : It is not safe to leave the patient alone and co-operation of the family members should be sought to ensure sympathetic supervision of the patient. Referral to a psychiatrist and admission under his care is warranted, if family members are not confident to look after the patient. When no psychiatric help is easily available treat the underlying psychiatric disorder either with drugs or psychosocial intervention or both.

2. Excitement : Excitement may be due to a) functional psychiatric illness like schizophrenia or mania, or sometimes post-partum psychosis, b) organic brain disorders caused by various CNS or systematic illnesses. When the excitement is due to either

schizophrenia or **mania,** it is rearely the first evidence of these illnesses. Often there will be history dating back to at least few days prior to the onset of excitement, of some behavioural abnormalities and sleep disturbances. usually there will be no confusion or other alternations in the state of consciousness. The clinical picture of **acute brain syndrome** would consist of fluctuations in level of consciousness, disorientation, inability to concentrate, impairment of memory - in addition to other features like restlessness, agitation, disturbances of sleep, slurred speech, irritability and unexplained fear.

Management : Excited patients generally carry the risk of self neglect, exhaustion and nutrition problems. If the patient is too excited to be without an escort, it is always advisable to choose an escort who has not physically restrained the patient before, because excited patients generally tend to be uncooperative with those who have physically and forcefully restrained them earlier. However, one should not hestitate to take whatever precautions a situtation may demand. For example, when dealing with a physically violent patient, it is wise to be out of his arms reach except while giving injections, and be always facing him. If the patient expresses hallucinations or delusions, respect it and do not argue.

The primary task in any excitement (**except head injury**) is **sedation.** Chlorpromazine 50 mg as im injection would be an ideal choice and should be given immediately. It can be repeated as injection of 50 mg upto a maximum 200 mg at half hourly intervals if necessary to control the patient. Later the injection should be substituted by tablets of 100 mg. Chlorpromazine given orally (300 to 400 mg per 24 hours can be sufficient). Fall of BP as a side effect of Chlorpromazine should always be kept in mind.

Following head injuries do not give any drug to the patient. Always admit for observation or refer to a hospital.

In treating the patient with acute brain syndrome, the underlying physical condition should be determined and energetic treatment for the same should be started as promptly as possible. Chlorpromazine in dosage of 50—150 mg orally can control the behavioural disturbances.

3. Stupor

This can be either a schizophrenic stupor or a depressive stupor. Though the patient is conscious, there is non-responsiveness to the surroundings, total absence of self care, neglecting physiological needs like food and fluid intake and almost total motor inactivity. These two conditions are emergencies because there is risk of neglect of nutritional needs of the body. Referral to psychiatrist and inpatient care is essential.

4. **Dystonic reaction** (as side effects of major tranquilizers)

The commonest side effect is extrapyramidal symptoms in the form of acute reactions like spasm of the muscles, especially of neck and face with difficulty in swallowing, manifesting as torticollis and/or occulogyric crisis which is very distressing to the individual.

Management : For immediate relief, im Promethazine (phenergan) 50 mg is given. Add antiparkinsonian agents orally, like Trihexyphenidyl hydrochloride 2 mg. twice or thrice daily. If the symptoms do not subside, refer to psychiatrist.

5. Lithium toxicity

In those patients who are on maintenance treatment with prophylactic lithium, and consulting you, be on the look out for toxic effects, and keep a watch. If the periodic serum lithium level is beyond 2m Eq/l, immediately refer the patient to the psychiatrist after stopping the drugs.

6. Hysteria

Though not an emergency in itself, may present as an emergency. Relatives of the patient may bring the patient as an emergency believing it to be so. The condition is **Hysterical Conversion Reaction.** This is because of the dramatic quality of the symptoms. A thorough examination of the patient, first of all for you to make sure of your diagnosis, and also to alleviate the anxieties of the relatives is essential. Then reassure the patient and the relatives that there is no danger to life and then proceed according to the clinical needs using the guidelines given for neuroses. (Chapters VI and IX).

HOSPITALISATION

In the primary health care setting in INDIA, there are only limited facilities for providing in-patient care. Usually the number of beds available is 6-12 at the primary health centres. These are utilised for acute physical problems like severe dehydration, or delivery of women. Hospitalisation of psychiatric patients is not thought possible at this level. However, experience of training medical officers have shown that there are some situations that the PHC doctor comes across when hospitalisation for short periods becomes essential. This section deals with these situations and how to provide care and organise the services in the hospital.

There are **THREE TYPES** of clinical situations where hospitalisation is appropriate, namely,

(i) **Psychiatric Emergencies** like status epilepticus, severe degree of

extrapyramidal symptoms, severe excitement and acute hysterical symptoms. In these situations the stay in the hospital will vary from a few hours to 24 hours. It is essentially to provide more intensive care under supervision, to be followed by referral to a bigger health facility or home treatment. Management of these conditions is considered in earlier section. The general approach in these situations would be to see the patient every half to one hour and assess the progress, ensure that a relative is always staying with the patient, maintain records to be sent to the referral hospital and ensure adequate nursing care.

(ii) **To Initiate Intensive Treatment** in cases where hospitalisation would be ideal (acute organic psychosis, mania, depressive stupor, suicidal patient, post epileptic psychoses, psychosis, following childbirth, psychosis with physical problems like diabetes or hypertension) you will find that relatives do not want to go to a bigger hospital or they would like you only to treat the patient. Initially a PHC doctor may feel that it is not possible to do anything.

However, experience has shown that doctors can admit such patients for **few days** in the PHC facility and provide treatment. The purpose of this hospitalisation is to use the drugs under supervision, to adjust the dosage from day to day, to prevent harm to patient or others. When hospitalised, patients can get parenteral medicine (chlorpromazine) to control psychotic symptoms rather than place them on oral drugs. In any hospital facility, use of chrorpromazine 50 mg im every four to six hours will be possible. With this regime most acutely disturbed patients come under control in 2-4 days. In addition, the few days in the hospital setting will also convince the relatives the usefulness of medical help and they would be more willing to take and follow the advice of the doctor. The safety precautions under psychiatric emergencies apply here also. It has been noted that with experience there is very little need for referral to a psychiatric centre for most patients seen in PHC.

(iii) **Hospitalisation for Diagnosis** become important in situations where the information available at the OPD level both from relatives and examination is not adequate for arriving at a diagnosis. Some such situations are the differentiation between hysterical fits and epileptic fits, doubts about organic psychosis, occurrence of side effects which are unusual. In these situations short admission and observations will clarify the problem. Such efforts from you will save the patient's visit to a specialised psychiatric centre.

The above experiences are given to share the wider role a medical officer can play to meet the total needs of the **rural** population. As you start utilising fully all the facilities that are available, it will be found that more complete care can be provided at the PHC itself. It is best to have active referral link with the nearest psychiatrist.

LEGAL ASPECTS OF PSYCHIATRIC PATIENT CARE

Unlike persons with other medical problems, persons who have mental illnesses (insanity in the legal sense) come under some special legal provisions. They relate to admissions and discharge to mental hospitals (asylums), civil rights and criminal responsibilities.

In regard to admission to a mental hospital, patients can be admitted in 3 ways, namely:

(i) **Voluntary admission:** Where a patient gives in writing his desire to be admitted and treated for mental illness. The medical superintendent admits such patients and they can be discharged at any time and within 24 hours of request from the patient.

(ii) **Admission by reception order:** Under this procedure a relative of ill person makes a petition to the magistrate for a reception order. This request has to be in a specific form, which also includes a certified photograph of the patient, supported by two medical certificates, of which one of them is by a gazetted medical officer. The medical officers independently certify that they have seen the patient within the last one week and given reasons why it is opined that the person is a lunatic fit to be admitted to a mental hospital. The magistrate after receiving the request, medical officers certificates and seeing the patient can issue a reception order for admission to a mental hospital. These patients are discharged by the Board of Visitors or when a relative gives in writing his willingness to look after him once discharged.

(iii) **Admission of wandering lunatics:** Police personnel can initiate action on identifying this category of persons and through the magistrate admit them to a mental hospital.

The Indian Lunacy Act 1912 is the currently existing law that governs the mentally ill in India. A more progressive legislation **Mental Health Bill** 1981 is in the Parliament and provides for many changes regarding admission of psychiatric patients to mental hospitals and nursing homes when it is approved and enacted.

Mentally ill persons involvement in civil and criminal situations are covered by some special procedures. Issues of marriage, divorce, sale-purchase of property, ability to contest in an election, involvement in a crime are considered differently.

In view of the special situation, three aspects are important. Firstly, to maintain **detailed and regular records** of all contacts and observations. Secondly, to maintain total **confidentiality** of the information obtained as part of therapy contact. At no point

should personal details be provided to other persons not involved in the patients problems and treatment. One of the aspects of confidentiality is to keep the records in a safe place and not to discuss illness details in front of others. Thirdly, to be careful in assessing persons when legal reasons are the chief reason for contacting you. In such cases it will be best to refer them to a specialist.

X Implementation of Mental Health Care at Primary Health Care

As outlined in the National Mental Health Programme for India (1982) the approach to organise services for the mentally ill by:

(1) Diffusion of mental health skills to the periphery of the health service system
(2) Appropriate appointment of tasks in mental health care
(3) Equitable and balanced territorial distribution of resources
(4) Integration of basic mental health care into general health services and
(5) Linkage to community development

The implementation of the mental health care programme requires the leadership of the medical officer as the leader of the primary health care team. It is important that every person in PHC gets involved in the care of the mentally ill persons. As different categories and levels of personnel are involved it is the medical officer who is the coordinating person.

The role of the MEDICAL OFFICER is to provide skills to the team members, ensure supplies, support and supervise their work and initiate community involvement. To be more specific, the medical officers will be providing treatment for the ill persons, monitor the work of the health personnel, becomes a link with more specialised services.

The responsibilities of the different categories of health personnel in mental health care are as follows:

Community health guides i) identification of cases, ii) referral and iii) mental health education.

Multipurpose health workers i) identification of cases, ii) first aid, iii) referral, iv) follow-up and v) mental health education.

Health assistants (Health inspectors and lady health visitors) i) first aid, ii) mental health education and iii) supervising the health workers.

Pharmacist i) mental health education and ii) compiling the data regarding drugs.

Staff Nurses i) first aid, ii) Nursing care of out patients and in-patients and iii) mental health education.

1. Training of non-medical staff in mental health care

The medical officer should train all the non-medical workers so that they become part of the management of mentally ill. This can be done easily during the monthly conference (or if possible, special classes can be arranged). Basic information about causes, presentation and treatment of mental illness, mental retardation and epilepsy should be given. More emphasis should be on early identification, referral and follow-up. Medical officer should demonstrate a few cases to health workers periodically. Manuals for the different categories of the health personnel are available.

For your convenience, the section on responsibilities of health workers is included as **Appendix I** in this manual. You can adopt this to suit your local needs and as a teaching aid. Possibility to translate this in local language and distribute them could be most considered.

2. Review of the programme in monthly meetings

Medical officer should enquire about each worker's contribution regarding identification, referral, follow up of psychiatric patients and mental health education. If there are problems, appropriate measures should be taken to solve them with the help of supervisory staff. The common problems are:

a) **An identified patient does not come to the clinic in spite of health workers effort:** After enquiring the details of the efforts made by the workers, doctor can ask the supervisory staff to visit the patients family or if needed doctor himself can do that and show them how the patient and family can be convinced to come to the clinic. Often the support of community leaders will be of great help in such situations.

b) **An irregular patient or a patient who has dropped out from treatment:** In every meeting, the medical officer should enquire about patients who are irregular or dropped out from treatment and initiate specific efforts to see that all ill persons get full treatment.

SUPPORT AND SUPERVISION

Patient is referred to the clinic by the field worker: When the patient or his family members report that the health worker has referred them to the clinic, immediately the medical officer should appreciate it and express that he is happy about the work done by the worker. He should give credit to the worker so that the credibility of the worker is increased in the community. Medical officer should check the referral slip sent by the worker. After examining and initiation of the

treatment, doctor should tell the patient and family of the treatment and he should tell the patient and family members to contact the health workers for additional help and guidance regarding the management of the patient. Information regarding the patient's illness and management should be given to the health workers at an early date through their supervisors.

Irregularity of treatment by a patient: Health workers are asked to find out the reasons for the same. The reaons may be side effects of the drugs, fits not being controlled in spite of medication and family members losing faith in the drug, patient not willing to take drugs, difficulties to come to the hospital like distance, poverty etc., family members trying traditional methods of treatment. The health workers and supervisory staff should be instructed to make a few more attempts to convince the patient and the family members to come regularly for follow up. Medical officer should take appropriate measures to overcome these difficulties as outlined earlier mobilising community resources.

Medical officer should recognise the good work done by health worker and encourage everybody to contribute to the care of mentally ill. If necessary and wherever possible medical officer should make home visits and demonstrate to the health workers how to convince them to accept the treatment.

Records and reporting: The medical officer will be maintaining simple case records of patients whom he treats. He will collect data regarding the work of health workers with the help of supervisory staff. He should prepare a monthly report regarding new cases identified, number of patients on treatment, number of cases dropped out, drug position and submit to District Health Officer (DHO, CMO) during the monthly conference at district headquarters. He should discuss the achievements and difficulties of implementing the programme.

MENTAL HEALTH EDUCATION

It has been already noted that there are large number of misconceptions in the community. Of all the health problems, mental illnesses are poorly understood by the general public. This has been the reason for people to seek non-medical help from healers, priests, **mantravadis** and seek refuge in places of pilgrimage.

Change in the community awareness is central to the success of the health programmes. With this in view all efforts should be made to enhance the knowledge of all members of the community and not only the ill persons. A more detailed account of this is given as **Appendix II** which is already part of the manual of MPWs.

As a medical officer you can carry out mental health education by: (i) Providing correct information and correcting wrong beliefs and practices in the patient-family-doctor

contacts in the clinics. Informed and improved patient can bring about changes in the community. (ii) Utilising the mental health education material in this manual as a topic in your community meetings. For example as an additional topic in the orientation training camps (OTC) along with family welfare information (iii) Reviewing mental health education activities along with other health activities in the monthly meetings of the PHC team.

In addition you would be receiving pamphlets, charts, films for distribution among the public. As the leader of the health team you have both the responsibility and opportunity to bring about changes in the community and health personnel and bring new hope for the long neglected mentally ill individuals in the rural areas.

Lastly, this **'manual'** has been the result of our work since 1975 working with primary health care personnel. We would like to hear from you, your reactions to the utility of the manual, your experiences and suggestions for improvement. Please do write to tell us of your experiences.

Appendix—I

Chapter 10 from Manual of Mental Health for Multipurpose Workers (1985)
Ed: R. Srinivasa Murthy

RESPONSIBILITY OF HEALTH WORKERS

HOW CAN YOÙ HELP THE MENTALLY ILL AND DISABLED IN YOUR COMMUNITY?

Now you know that there are several mentally ill and disabled in the community. Most of them do not get any meaningful treatment, with the result that they as well as their family members suffer. You will come in contact with them, while carrying out your routine health care activities. If you can assist in delivering mental health care to those in need of it most of them can improve and become useful members in their families and community. **Along with your regular health care responsibilities, you can do the following:**

I. **Identify all the persons with mental illness and epilepsy in the population covered by you.**
II. **Provide first aid in emergencies.**
III. **Refer the identified patients to the PHC/PHU doctor**
IV. **Follow up these patients regularly.**
V. **Educate the family and community in taking care of these patients**

I. IDENTIFICATION OF PATIENTS IN THE COMMUNITY

You will already know of some patients in the villages you work. You are likely to see some of them in future during your work. In addition, you must actively enquire about similar patients who may not be known to you. This can be done in the following ways:

(i) When you go to a village for your routine work, talk to important people like village panchayat members, local leaders, teachers, educated youth, members of service agencies like anganwadi, mahila mandals, youth clubs and shop keepers or hotel owners. Request them to tell you about individuals:

1. **Who talk nonsense and act in a strange manner considered abnormal.**
2. **Who has become very quiet and does not talk or mix with people.**
3. **Who claim to hear voices or see things others cannot hear or see.**
4. **Who are very suspicious and claim that some people are trying to harm them.**

5. **Who have become unusually cheerful, crack jokes and say that they are very wealthy, and superior to others when it is not really so.**
6. **Who have become very sad lately and cry without reason.**
7. **Who talk about suicide or have made an attempt at suicide.**
8. **Who get possessed by God or spirit or who is said to be the victim of black magic or evil power.**
9. **Who suffer from fits or loss of consciousness and fall down.**
10. **Who are dull, not mentally grown up like others of their age and slow since birth.**

Tell them that these conditions can be helped and now such help is available at nearby PHU or PHC. Request them to refer such patients to you or to the hospital. Every time you meet them, remind them to do this.

(ii) When you visit **homes** enquire about people who are suffering from mental illnesses. Ask the above questions tactfully without offending the members and obtain information about the existence of a patient in that family, neighbourhood or among their relatives.

(iii) When you go to a **school,** to carry out immunisation and other school health programmes, enquire from the teachers and students about children who get fits, who have behavioural or learning problems. Identify them, get details and refer them to a doctor.

(iv) When you carry out immunisation of the **children** in the village, enquire from mothers about children who have limited mental abilities and have poor development. Thus you can easily identify mentally retarded children.

(v) When you do the follow up of persons, who have **undergone family planning operations,** look for those who have multiple bodily symptoms and who feel very unhappy. These can be due to emotional problems. You can identify depressive illness in this manner.

As noted above you can identify mental patients during your routine work with little extra effort and be sensitive to those who contact you for other problems. When you identify a patient, do the following:

(1) Talk to the family members and encourage the patient and family members to give a detailed account of the symptoms, their duration and severity. Get details about patient's talk and behaviour and how it has affected others in the family and community.

(2) Find out how the illness started - whether sudden or gradual – was there any

precipitating event like fever, fits, head injury, quarrel, loss or any other problem? Find out the duration of the illness.

(3) Check specifically whether the following symptoms are present

a) Sleep disturbance
b) Poor appetite/irregular food intake
c) Not doing any work
d) Not attending/maintaining personal hygiene
e) Disturbed relationship with family members & others
f) Exhibiting behaviour which is harmful or troublesome to others like being abusive, assaultive, suicidal or homicidal.
g) Any bizarre or socially unacceptable behaviour like undressing in public,collecting rubbish, wandering away from home.

(4) What have the family members done? What treatment has been given and what is the result? What do they think about the illness and the patient.

Fill up the simple record and follow up form.

Identify whether the patient is suffering from epilepsy, psychosis or mental retardation. **Decide whether it is an emergency or not** (Details of the type of problems which should be referred immediately to the doctor are given later on in this chapter).

Presentation of mentally Ill

Mentally ill people can present in the following ways:

1. Noisy and excited
2. Dull and withdrawn
3. Suspicious (paranoid)
4. Confused
5. Apparently normal

★ **Excited patient**

What can you do when you see an excited restless patient?

1. Advise others not to talk or behave in a way that irritates or provokes the patient. Keep away individuals whom the patient does not like.
2. Do not confront (argue, scold) the patient or provoke him.
3. Try to gain his confidence by enquiring 'What are your problems? Why are you so angry? Who is troubling you? I am here to help you.'
4. When he calms down, see that he takes some fluids and food.

5. Try to convince him that he needs some medicines and it is better if he can come and see the doctor.

★ Withdrawn patient

When you see a patient who is dull, withdrawn

1. Take time to talk to the patient
2. Persue him to eat something
3. Find out whether he feels like ending his life
4. Convince him to take treatment from the health centre and take medicines.

★ Suspicious patient

You must be careful when you have to approach a suspicious patient who does not trust any one.

1. Be fair and honest. Do not tell lies or hide facts.
2. Do not question his beliefs or suspicions. Do not tell that his beliefs are wrong, baseless or false.
3. Allow him to talk about his suspicions. Collect more information. Do not pass any judgement.
4. Draw his attention towards his other problems like sleeplessness, decreased appetite etc., and convince him to see the doctor and take medicines.

★ Patient with confusion

Confused persons do not recognise others, make errors in calculation and have poor memory.

1. Find out whether he had jerky movement (fits) of the limbs. It could be following epilepsy.
2. Find out whether he is a known case of diabetes or high blood pressure.
3. Enquire whether he has had a recent head injury or has consumed alcohol.
4. Tactfully find out whether he has consumed some drugs with an intention to commit suicide.
5. Examine to see if he is having high fever.

All confused patients should be referred to the health centre as soon as possible. It is better to avoid giving anything to the patient by mouth (to drink/eat). Presence of strangers, and unwanted disturbances around the patient are also better avoided.

REMEMBER

- ★ Do not over promise the patient or his people
- ★ Do not say that you will do everything. Do not make all the decisions for the patient's family.
- ★ Do not criticize others. Do not blame anybody.
- ★ See that family members make the important decisions.
- ★ If you are a male, do not interview a female patient alone.
- ★ See that they develop confidence in their abilities. Do not make people totally dependent on you.
- ★ Reasssure that you would do your best to help them. Let them not think that you are superman.
- ★ Avoid half hearted attempts. Hard work gives good results.

II. FIRST AID

First aid in psychiatric emergencies

You may be in situations where patients will be in need of urgent help but the PHC doctor is too far away or not available. Under these circumstances, you must offer immediate help. The following are the circumstances in which you can offer help.

★ When you see a violent or very excited patient

1. Keep some distance from the patient and try to find out from him the reasons for his anger and who are troubling him.
2. Take the help of a person in whom the patient has confidence.
3. If the patient is not in a position to listen to you, throw a blanket on the patient and hold him with the help of others. Take him immediately to the hospital.
4. Do not use thread, rope or chain to restrain him. If necessary, use only a towel or long cloth to tie his hands.

★ Suicidal patient

Whenever a patient threatens that he wants to kill himself, take his words seriously. See to it that someone is always with the patient till he is taken to a doctor.

1. Quickly find out the problem which made the patient to decide to commit suicide.
2. Talk to the patient so that he looks at you as a well wisher. Tell the patient that you will assist him/her to solve the problems.
3. Listen to the patient with sympathy and encourage him/her to talk about the problems in detail.
4. Take the patient to the doctor yourself or refer him to the doctor immediately, along with a relative.

★ Patient with continuous fits

Sometimes, patients, usually children, get fits continuously, one after the other and in between they remain unconscious. This is an emergency and fits have to be stopped immediately otherwise it can lead to brain damage or even death. Therefore if a child/person gets a second fit a few minutes after the first, arrange for doctors help immediately.

III REFERRAL

Following the identification of the patient and giving first aid whenever necessary, you will refer the patient to the PHC as early as possible. Find out the head of the family who can take decisions and entrust the responsibility of the patient to this person. You can accompany the patient to the hospital when possible. **Send a referral note to the doctor giving details that you have noted.** Provide all details of the place of treatment, to the family like name of the place, and the person to be contacted and working hours of the centre.

During your next visit to that family, find out whether they consulted the doctor. If they have not done it, find out the reasons and encourage them to do so.

Refer the patient immediately to the doctor in following conditions:

1. The patient is severely ill, violent or unmanageable at home.
2. There is history of recent head injury.
3. The patient has fever, severe headache, vomiting or fits.
4. The patient has attempted suicide and is still threatening to commit suicide.
5. The patient is getting fits repeatedly (more than 3 times a day or continuously)
6. Disturbed behaviour has occurred following child birth.
7. Disturbed behaviour occurring for the first time, after the age of 40 years.
8. Disturbed behaviour in persons with known diabetes or high blood pressure.
9. Persons who show abnormal behaviour after taking alcohol.

IV. FOLLOW-UP

As part of the total management patient will be examined by the doctor. The nature of the illness is diagnosed and treatment is started. Due to any reason if the patient discontinues the treatment, all your efforts and the efforts of the doctor and family members become fruitless. Therefore during every visit you should meet the patient and the family members and enquire:

1. Whether the patient is taking medicines regularly as prescribed.
2. How much improvement has he made.
3. Has he developed any side effects with drug use.
4. Whether the patient has started working again.
5. Whether the patient has seen the doctor for follow up and review. Collect the above information in these areas. The foliowing section deals with handling of problems that can come up during follow up.

1. Side effects

Different types of drugs are used for the treatment of mental disorders. Sometimes these may have side-effects which are unpleasant to the patient and he may give up the drugs. You already know about the kind of side effects these drugs are likely to produce. First thing to do is to reassure the patient if the side effects are mild. However, remember to refer him to the doctor immediately if they are severe. **All changes in the drug dosage should be carried out by the doctor.**

Drugs given to the mentally ill can have mild side effects which are temporary; examples of this are, dryness of mouth, light headed feelings and constipation. When the patient complains of the above, reassure him that it is temporary. Dryness of mouth can be helped by taking more water or keeping a piece of lemon in the mouth.

However, **severe side effects** can also occur. Examples of these are continuous light headedness, unsteadiness, stiffness of limbs, limbs getting pulled in different directions, twitching of tongue, mouth, neck or hands and legs. At times he can have unclear speech, drooling of saliva. **If any of the above are present send the patient to the doctor immediately.**

Another problem is **drowsiness.** When a patient is very excited he is put on higher doses of drugs. But as he gets better he needs lesser doses and if the dosage is not reduced, he can have drowsiness. However the drugs should not be stopped. The patient should be taken to the doctor to reduce the medications suitably.

Patients who are **very sad and depressed** are given drugs which must not be stopped suddenly. If they are stopped suddenly they will get back the symptoms. These drugs should always be stopped gradually over a few weeks. These drugs take time to show the effects. Usually, patients report improvement after a week of starting the drugs.

An **epileptic patient** is given drugs which can have the following side effects. Excessive sleep or unsteadiness and slurring of speech. Ask him to see the doctor immediately.

REMEMBER

- ★ Tell the patient to take drugs as prescribed by the doctor.
- ★ Patient should not make any changes in the dose without consulting the doctor.
- ★ If patient has any difficulty or doubt regarding the drugs, he should consult the doctor.

Appendix—II

Chapter 9 from Manual of Mental Health for Multipurpose Workers (1985)
Ed: R. Srinivasa Murthy

MENTAL HEALTH EDUCATION

Of the many health problems (illnesses) mental illnesses are poorly understood by the general public. This has been the reason for people to seek non-medical help from healers, priests, mantrawadis and to go to places of pilgrimage. People using these methods do harm to the patient by delaying treatment. **As you know in all illnesses early recognition and treatment gives the best relief.**

As the belief and practices in our community have been there for many years, they will not disappear in a short time. In addition, these ideas are firmly held by even the educated and the leaders of the community. There is no quick way to make people believe in what you know is the right method of dealing with problems. **Your repeated efforts to give the correct information will lead to change.**

As an example, about 20 years back if someone got an attack of malaria fever, the shivering was thought to be due to possession of spirits. They did not believe it was due to malaria parasite in the blood. However, now, as you know, people know malaria fever can be treated by chloroquine and ask you for 'malaria tablet' as soon as a person has fever. Your continued efforts and willingness to hear their beliefs and be with them during their times of trouble will lead to change of belief, their attitude to the illness and to give up the old practices and accept medical treatment.

Following are some of the common questions asked by the public about the mental disorders. You can also use these questions as points to build up your health talk. The answers are guidelines for you to develop according to the local needs. **It is important that in providing new information you will avoid giving the new ideas in a matter of fact manner and be patient and make enough time to clarify the doubts and fears.**

QUESTIONS ABOUT MENTAL ILLNESSES

Q.1. **Are mental illnesses hereditary?**

A. Children of mentally ill persons do not necessarily become mentally ill. Children of most patients remain healthy and lead a normal life.

Q.2. **Is mental illness contagious? By living with the patient, do others become ill?**

A. Mental illnesses are not contagious and do not spread from one person to other.

Q.3. **Do ghosts, black magic, evil powers, God's curse cause mental illness?**

A. In olden days people did not know that changes in the brain are the cause of mental illnesses, they believed that ghosts, black magic, evil powers are responsible for the illnesses. Similarly in olden days diseases like cholera, malaria, small-pox were believed to be caused by these super-natural powers. Today we know that there are other causes for these diseases. **Changes and diseases of the brain, severe stress and strains in the family-social environment cause mental illnesses.**

Q.4. **Does masturbation, night discharge, loss of semen cause mental illnesses?**

A. Masturbation and night discharge are normal events in our sexual life. They are harmless. Loss of semen does not cause any weakness or bad effects.

Q.5. **Does drinking alcohol cause mental illness?**

.A. Alcohol is harmful to the brain cells. Taking alcohol regularly for long periods leads to various types of severe mental illnesses.

Q.6. **Is mental illness treatable? Do drugs help?**

A. Drugs are an important way of treating mental disorders. Mental illnesses are treatable. Drugs when taken, set right the imbalances in the brain and symptoms become less and disappear. Like physical illnesses, mental illnesses respond to treatment.

Q.7. **Is it always necessary to admit mental patients to a mental hospital?**

A. It is not necessary. Mentally ill persons can take medicines at home and with the help of family members can recover fast. In some cases admission into a mental hospital delays recovery. Therefore managing the patient in his own home/village is best. In some cases mental hospital psychiatric ward in general hospital is useful when the person has special needs like treatment of associated physical problems, use of treatments like ECT or for rehabilitation.

Q.8. **Can marriage cure mental illnesses?**

A. A mentally ill person can get worse if he gets married when he is ill. Marriage can become an additional stress. A patient who has recovered can get married and live a normal life like any other person.

Q.9. **Can improved patients take responsibilities, like working?**

A. Mentally ill persons can work and take responsibilities. When they are ill somebody has to supervise them. After recovery, they can lead a life, like any other person. Only a few patients have to work under supervision.

II. About Epilepsy (Fits)

Q.1. **Are 'fits' contagious?**

A. They are not contagious. By seeing a fit or by touching the froth, one does not get a fits.

Q.2. **Are fits caused by evil spirits entering the body?**

A. Fits are the result of abnormal electrical activities in the brain.

Q.3. **Does branding cure or stop the fits?**

A. Branding does not help. It causes a lot of pain and suffering to the patient.

Q.4. **Are there drugs for fits?**

A. Very effective drugs are available. Patient has to take them regularly as told by the doctor. Fits are controllable.

Q.5. **Should we go to a specialist to get this treatment?**

A. It is not always necessary. Majority of the patients can be treated by the doctor at the nearest health centre.

Q.6. **What should we do when we see a person getting a fits? Does placing an iron-object in the hand stop the fits?**

A. You can help a person with a fits as follows:
Turn the patient to a side so that mouth secretions will not choke him to death. Make some space for the patient and remove harmful objects present near him. Do not place any hard object between his teeth. Do not hold his limbs. As soon as the movement stops, see that he starts breathing.

Keeping an iron object in hand does not help in any way. Always advise patient to take medical help without delay.

Q.7. **Can the patient work? Can a child with fits go to school?**

A. Persons with epilepsy should work like other people. Children should go to school. Once fits are controlled with drugs they can work like everybody. Initially they should not work near fire, water, moving machinery or drive any vehicle.

Q.8. **Should we give special kind of diet to the patient? Are there any food restrictions?**

A. Patients can eat what they like. There are no special diets for persons with fits.

Q.9. **Can the patient marry? Can he/she have children?**

A. If fits are controlled, the patient can marry and have children. Women should seek the advice of their doctor when taking drugs before having a child.

III. About mental retardation

Q.1. **Why are some children retarded? Are parents responsible? Is it their fate or bad luck?**

A. Poor development of the brain or damage to the brain results in mental retardation. 2-3 out of 100 children are retarded. It is a medical problem and not due to fate, ones misdeeds or bad luck.

Q.2. **Are there medicines - tablets/tonics/injections or operation or other treatment methods to 'cure' mental retardation?**

A. Medicines do not help a retarded person to become normal. There is no treatment method which can make the brain grow again. If there are associated problems like fits drugs will be useful.

Q.3. **Is it possible to make the child better?**

A. It is possible to improve the retarded child. By training and making them learn various skills, they can function better.

Q.4. **Can he become independent? Can he look after himself?**

A. This depends on how you train him and how he learns. Our goals should be to make him as independent as possible. It also depends on the degree of damage to the brain.

Q.5. **Does marriage cure mental retardation?**

A. Marriage is not a cure for mental retardation. Moderate to severely retarded persons cannot take the responsibilities of marital life.

Appendix III—A

Registration No. . . . . .

PSYCHOSIS CASE RECORD

1. Name : ..... 2. Father's/Husband's Name : .....

3. Address .....

4. Distance from the health centre .....

5. Age yrs. 6. Sex : Male/Female 7. Date of registration .....

8. Mode of referral :
   1. Health worker-Name : ..... 2. Other patient
   3. Self 4. Identified in the clinic 5. Others (specify).....

9. Duration of illness : (Encircle the appropriate number)

   1. Less than 1 week
   2. 1 week - 1 month
   3. 1 - 3 months
   4. 3 - 6 months
   5. 6 months - 1year
   6. 1 - 3 years
   7. 3 - 5 years
   8. More than 5 years
   9. Not known

10. Mode of onset : 1. Sudden 2. Gradual 3. Not known

11. Precipitating factor : 1. Present 2. Absent

    If present, details .....

12. Associated events 1. Fever 2. Alcohol/Drug intake 3. Head injury 4. Physical illness

13. Type of illness : 1. Continuous 2. Episodic

14. Symptoms :(Encircle the symptom which is present)

    1. Excessive activity
    2. Violence
    3. Bizarre behaviour
    4. Dull/withdrawn
    5. Too much speech
    6. Too little speech
    7. Irrelevant speech
    8. Ununderstandable speech
    9. Firm, false belief
    10. Suspicion
    11. Elation/excess happiness
    12. Sadness
    13. Fear/anxiety
    14. Lack of interest
    15. Anger/irritability
    16. No emotion
    17. Suicidal ideation
    18. Suicidal attempt
    19. Disorientation
    20. Loss of memory
    21. Sleep of disturbance
    22. Lack of memory
    23. Self neglect
    24. Sexual problems

25. Somatic pains (Mention) .....

26. Any other : (Specify) .....

15. Past history of mental illness : 1. Present 2. Absent

If present, type : 1. Psychosis 2. Neurosis

16. Family history of psychosis : 1. Present 2. Absent

17. Signs

1. Sensorium	: 1. Clear	2. Clouded	3. Unconscious	
2. Appearance	: 1. Clean	2. Unclean		
3. Behaviour	: 1. Restless	2. Dull	3. Suspicious	4. Normal
4. Talk	: 1. Normal	2. Too much	3. Too less	4. Irrelevant
5. Delusion	: 1. Present	2. Absent		
6. Hallucination	: 1. Present	2. Absent		
7. Mood	: 1. Elated	2. Sad	3. Angry	
	4. No emotion	5. Normal		
8. Suicidal	: 1. Severe	2. Moderate	3. Mild	4. Nil
9. Memory disturbance	: 1. Present	2. Absent		
10. Insight	: 1. Present	2. Absent	3. Partial	
11. Physical exam	: 1. Normal	2. Abnormal (specify)		

.....

12. Any other, specify .....

8. Diagnosis 1. Schizophrenia 2. Mania 3. Depression

4. Organic psychosis 5. Other psychosis

19. Mode of management : 1. Managed at PHC 2. Refer to a bigger hospital

20. Treatment : 1. Drugs 2. Drugs + Counselling 3. Counselling only

21. Drugs prescribed :

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Health Centre : Signature of the M.O.H.

Appendix III—B

Registration No.....

NEUROSIS CASE RECORD

1. Name : .....2. Father's/Husband's Name : .....

3. Address .....

4. Distance from the health centre .....

5. Age yrs. 6. Sex : Male/Female 7. Date of registration :.....

8. Mode of referral :

   1. Health worker-Name : ..... 2. Other patient

   3. Self 4. Identified in the clinic 5. Others (specify) .....

9. Duration of symptoms :

   1. Less than 1 week
   2. 1 week - 1 month
   3. 1 - 3 months
   4. 3 - 6 months
   5. 6 months - 1 year
   6. 1 - 3 years
   7. 3 - 5 years
   8. More than 5 years
   9. Not known

10. Mode of onset : 1. Sudden 2. Gradual 3. Not known

11. Precepitating factor : 1. Present 2. Absent

    If present, details .....

12. Symptoms : (Tick whichever present)

    1. Fear
    2. Palpitation
    3. Giddiness
    4. Increased sweating
    5. Dryness of mouth
    6. Tremors
    7. Difficulty to concentrate
    8. Impaired memory
    9. Sadness
    10. Lack of interest
    11. Deathwish/suicidal ideation
    12. Suicidal attempt
    13. Fits/Falling unconscious
    14. Other Hyst. symptoms (specify).....
    15. Headache
    16. Other body aches/pains
    17. Weakness
    18. Fatiguability
    19. No/less appetite
    20. Sleep disturbance
    21. Sexual problems (specify) .....
    22. Others (specify) .....

13. Stress factors :

    1. Family 2. Financial 3. Occupation 4. Sexual
    5. Others (specify) ..... 6. Absent
    Details .....

14. On examination

    1. Signs of anxiety 2. Signs of depression
    3. Physical illness (specify) ..... 4. Normal

15. Insight 1. Present 2. Absent 3. Partial

16. Diagnosis :

1. Anxiety neurosis 2. Depressive neurosis

3. Hysteria 4. Others (specify) .....

17. Treatment : 1. Drugs 2. Drugs + Counselling 3. Counselling

18. Drugs prescribed :

.....

.....

19. Psychological help : .....

Health Centre :

Signature of the M.O.H.

Appendix III—C

Registration No .....

MENTAL RETARDATION CASE RECORD

1. Name : .....
2. Age ..... yrs. 3. Sex : Male/Female
4. Father's Name : .....
5. Address .....
6. Distance from the health centre .....
7. Mode of referral :
   1. Health worker-Name : .....
   2. Other patient 3. Self/family 4. Others
8. Date of registration :
   1. Poor motor development 2. Delayed milestones
   3. Dull 4. Hyperactive
   5. Speech problems 6. Physical handicaps
   7. Fits 8. Scholastic backwardness
   9. Lack of self care 10. Lack of social sense
   11. Other (specify) .....
10. Present : 1. Since birth 2. Later in life (specify the age of onset) .....
11. Consanguinity among the parents : 1. Present 2. Absent 3. Not known
12. Family history of: 1. Mental illness 2. Mental retardation 3. Epilepsy 4. Nil
13. Mother's health :
    1. Age at pregnancy (for this child) : 1. Below 30 years 2. 31-40 yrs. 3. 41 years +
    2. Birth order : 1. First 2. Second 3. Third 4. Fourth 5. Fifth
       6. Sixth and above (specify) .....
    3. Prenatal : 1. Healthy 2. Poor nutrition 3. Illness (specify)
    4. Natal : 1. Difficult labour 2. Forceps/caesarian 3. Delayed birth cry
       4. Signs of hypoxia 5. Premature.
    5. Postnatal (child) : 1. Poor nutrition 2. Fits 3. Infection 4. Head inujury
14. Developmental milestones : Delayed Normal
    1. Holding neck erect :
    2. Sitting :
    3. Standing :
    4. Walking :
    5. Speech :

15. Physical examination : 1. Normal 2. Abnormal (details)

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16. Abilities of the child : (Tick the appropriate)

1. Able to stand 2. Able to walk
3. Toilet control 4. Able to feed itself
5. Able to dress itself 6. Able to speak
7. Able to do simple work 8. Others (specify) .....

17. Diagnosis : 1. Mild M.R. 2. Moderate M.R. 3. Severe M.R.

18. Associate problems :

1. Behavioural problems 2. Hyperactivity
3. Physical handicap 4. Epilepsy

19. Treatment :

1. Drugs (specify) .....
2. Counselling .....
3. Immediate task of training advised (specify)

.....

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Health Centre : Signature of the M.O.H.

Appendix III—D

Registration No.....

EPILEPSY CASE RECORD

1. Name : .....
2. Age ..... yrs. 3. Sex: Male/Female .....
4. Father's/Husband's Name :.....
5. Address : .....
   .....
6. Distance from health centre .....
7. Date of registration :
8. Mode of referral :
   1. Health worker-Name :.....
   2. Other patient
   3. Self
   4. Identified in the clinic
   5. Others
9. Duration of illness
   1. less than 1 week 2. 1 week/month
   3. 1 - 3 months 4. 3 - 6 months
   5. 6 months - 1 year 6. 1 - 3 years
   7. Upto 5 years 8. More than 5 years
   9. Not known
10. Frequency of fits : per day per month per year
11. Cluster/status : 1. Present 2. Absent
12. Last attack on .....
13. Description of the attack : Put a tick mark against the relevant items
    1. Aura
    2. Focal onset
    3. Unconsciousness
    4. Sudden fall
    5. Injuries
    6. Tonic/clonic movements (regular, sinchronous)
    7. Tongue bite-bleeding
    8. Urinary/foecal incontinence
    9. Post ictal symptoms
    10. Attack during sleep when alone
    11. At specific time/places only
    12. Changing pattern

14. Associated events : 1. Fever 2. Hot water bath

3. Head injury 4. Alcohol intake

5. Physical illness .....

15. On examination :

1. An attack precipitated by suggestion
2. Neurological deficits present
3. Normal

16. Past history of epilepsy : 1. Present 2. Absent

17. Family history of epilepsy : 1. Present 2. Absent

18. Diagnosis :

1. Major epilepsy 2. Focal epilepsy
3. Focal - Generalised 4. T.L.E.
5. Febrile fits 6. Others .....

19. Associated disorder :

1: M.R. 2. Behavioural problems

3. Neurosis 4. Psychosis

5. Others ..... 6. None.

20. Drugs : 1. Prescribed 2. Not prescribed

21. Drugs prescribed :

Health Centre : Signature of M.O.H

FOLLOW-UP RECORD

1. Name :..... 2. Village : .....

3. Age ..... years. 4. Sex : Male/Female

5. Drugs prescribed :.....

.....

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Date	Drug intake	Follow up detail	Drugs dispensed	Due on

Appendix IV

Time Table for a Short Course in Mental Health for Medical Officers

Day	Forenoon	Afternoon
1.	Reporting, getting to know each other. Introduction to training programme.	Pre-training assessment with video cases/case stories.
2.	Magnitude of mental health problems in our country, need to integrate mental health with general health services. Brain and Behaviour	Mental illness — features, types, causes and treatment.
3.	General approach to psychiatric patients. History taking and mental state examination. Role play exercise.	Discussion on features of different types of psychosis.
4.	Working up of psychosis cases and discussion.	Discussion on organic psychosis.
5.	Seeing ECT, working up of psychosis and discussion.	Discussion (contd).
6.	Epilepsy : Types, causes and management	PHC visit.
7.	Neurosis : Features, causes and types. Management of Neurosis	Principles of counselling and Psychotherapy
8.	Legal aspect of psychiatry : Case work up and discussion	Mental Health education/video.
9.	Teaching health workers : Preparation and practical demonstration exercise. Role-play.	Mental retardation and its management
10.	Visit to various wards. Visit to mental retardation clinic	Visit to physical medicine and rehabilitation department.
11.	Childhood psychiatric disorders Psychopharmacology	Implementation of mental health programme, discussion of problems
12.	Post-training assessment	Reviews of the programme Certificate distribtuion.

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